Maternal and Child Health Services
Title V Block Grant

State Narrative for Montana

Application for 2012
Annual Report for 2010

Document Generation Date: Wednesday, September 14, 2011

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Montana Department of Public Health and Human Services complies with all required assurances and certifications for federal grants. Copies of the required documents may be accessed through the Director's Office at http://www.dphhs.mt.gov/directorsoffice/.

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D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The Family and Community Health Bureau (FCHB) is the designated Title V Agency for Montana. The Bureau's goal for the 2010 needs assessment and the 2011 MCH Block Grant Application and 2009 Annual Report was to ensure active, public input and partner involvement in the planning of those documents and reports.

The Family Health Advisory Council was not reappointed by the Governor in 2009, due in part to an effort to decrease the number of advisory groups. Instead, the Public Health System Improvement (PHSI) Task Force, a group already charged with overseeing and providing input to Montana's Preventive Health and Health Services Block Grant was selected to provide public input. The PHSI was established in 1993 with the purpose of advocating for statewide public health improvement efforts. Its membership includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties) and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. Additional information about the PHSI Task Force is included as an attachment.

In order for the MCH Needs Assessment process to be effective, the needs assessment participants were briefed on the yearly MCH Block Grant Application and Annual Report contents. As mentioned elsewhere in this document, i.e. II. Needs Assessment, C. Needs Assessment Summary and in more detail in the 2010 Montana Maternal and Child Health Needs Assessment document, there were numerous venues for public input. Over the course of developing the 2010 Montana Maternal and Child Health Needs Assessment, 226 health care professionals; 115 MCH partner organizations; 40 key informant interviewees; and 49 parents who had children with

special health care needs, 53 adolescents, and 49 parents of children aged 0 to 12 years through their participation in Focus Group discussions held in four communities and one American Indian Reservation. All of these individuals were enlightened on the MCH Block Grant Application and Annual Report.

The 2010 MCH Needs Assessment and the 2011 MCH Block Grant Application and 2009 Annual Report will be posted on the FCHB's webpage after July 15, 2010. At that time, the PHSI Task Force members and the interested parties will be sent information electronically about the documents' posting and they will be invited to offer their comments on these documents. To simplify this process, the FCHB has created a separate email account HHS MCH BlockGrant@mt.gov, for comments that will be shared with the FCHB and the PHSI Task Force. These comments will also be used, when applicable, on future MCH Block Grant applications.

The FCHB will continue to solicit input on the yearly application through the Pre-Contract Survey, which is contractually required of the health departments accepting MCH Block Grant funding. Additionally, the PHSI Task Force which meets regularly will be kept apprised of the MCH Block Grant Application and Annual Report.

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The 2011 MCH Block Grant Application and 2009 Annual Report were posted on the FCHB webpage and partners, i.e. local health departments, state and community based agencies were informed of their opportunity to provide comments using the email account HHS MCH BlockGrant@mt.gov. No comments were received using this method.

At each of the six Montana regional Maternal and Child Health Meetings, co-sponsored using SSDI and MCH BG funding, comments were received on the 2011 MCH Block Grant Application and 2009 Annual Report. Attendees were queried on nine topic areas that were covered by the MCHC Section Supervisor and Lead FCHB Epidemiologist and on future topical areas. The results are included on the attached 2010 MCH Regional Meetings Evaluation Summary. The MCHC and Epi Units anticipate offering Regional Meetings the fall of 2011. See the attachment: Public Input Evaluation Summary.

The PHSI Task Force membership was being reappointed at the time of the July 2011 submission. The PHSI Task Force will have an opportunity to review the August 2011 comments and offer input prior to the September 2011 final submission. The final PHSI Task Force reappointments were not completed by the 9/14/2011 final submission date.

A CSHS parent representative reviewed the CSHS 2012 MCH Block Grant performance measures Because this was her first opportunity to do so, most of her feedback was seeking clarification about the grant application process and ability to follow the material given the TVIS character limits. Additionally she provided feedback about opportunities to conduct additional surveys and projects with additional resources in the CSHS program. Based on parent feedback, CSHS will propose to the CSHS Advisory Committee to allot time at the next meeting to review the CSHS performance measures of the 2013 MCH Block Grant Application.

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An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2012, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Family and Community Health Bureau (FCHB) regards the needs assessment process as an ongoing, bureau-wide activity due to the interest and involvement of state and local partners -- particularly those who contract for MCHBG finding -- in improving MCH in Montana. To continue to build on the 2005 Needs Assessment, an existing Bureau team with membership from all programs in the Bureau was expanded and became the Needs Assessment Team that developed a process for the 2010 needs assessment.

A statewide preliminary planning survey was conducted in the summer of 2008 with MCH partners to solicit feedback regarding previous methodologies, data gaps, and representation. This survey resulted in an initial list of priority needs and recommendations for conducting the needs assessment and an overall suggestion for enhanced public input, greater partner involvement at the state and county level, and a systematic approach to identifying problems and possible solutions.

Montana's needs assessment process included focus groups with priority populations, surveys of public health professionals, and interviews with key informants who had MCH experience. The focus group populations were determined based on a review of data sources. Priority populations were selected, in part, to augment assessment for populations with limited data, including adolescents and parents of Children and Youth with Special Health Care Needs (CYSHCN). A survey of public health professionals, which was conducted in the summer of 2009, identified local organizations serving the MCH population in Montana. Key informant interviews provided in depth data from partners who worked in either a public or private MCH related organization.

The qualitative and quantitative data collected by the FCHB, was presented to the Public Health System Improvement (PHSI) Task Force in Winter/Spring 2010. The PHSI Task Force membership includes representatives of local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service. The Task Force was charged by the Division administrator with the responsibility to assist staff to finalize Montana's 2010-2015 list of MCH priority areas and performance measures.

During the previous needs assessment process, priority areas were developed independent of the performance measures. While all but one of the previous priority areas related to at least one state and national performance measure, they were more directly correlated with objectives in the Bureau's strategic plan. For the 2010 needs assessment process, priority areas were identified simultaneously with performance measures, and the relationship of those priorities to the Bureau and Division strategic plans was also considered. Only areas with an identified measure that were relevant at the state and/or local level were chosen. The 2010 -- 2015 MCH priority areas include: child safety/unintentional injury; access to care, with a focus on children with a special health care need, i.e. cleft lip and/or palate; preconception health; smoking during pregnancy; oral health; Montana's Varicella immunization requirement; and Montana's Diptheria, Tetanus, and Pertussiss immunization requirement.

The next step is the creation of action plans for the priority areas and related state performance measures through a cooperative activity between the state and local contractors. The MCH contracting process requires that local contractors complete a "pre-contract survey" in the spring

of each year, indicating the state or federal performance measure that local efforts will focus on during the contract period. Local contractors are also required to describe evidenced based activities they will employ to address the selected measure. In FFY 2010, local contractors are being asked to provide their selected activities as short, open ended answers on the surveys -- state staff will compile and categorize those responses by level of the pyramid in anticipation of the FFY 2011 pre-contract survey. State staff will research all proposed activities to find sound scientific evidence to support action plans being prepared at the state level. This participatory process allows locals to contribute to the development of action plans for performance measures.

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The 2010 -- 2015 MCH priority areas remained the same. The creation of the Office of Epidemiology and Scientific Support within the PHSD, has resulted in State Performance Measure 3 being revised to better reflect the state's capacity to implement activities and collect data.

Needs Assessment Topic Specific Summaries were created from the 2010 MCH Needs Assessment document and are available at: http://www.dphhs.mt.gov/PHSD/family-health/mchc/phsd-mch-assessment.shtml

The 2012 Pre-Contract Survey required each health department to develop a SY 2012 Operational Plan for their selected NPM or SPM. The MCHC Health Education Specialist will be working with and providing feedback to the health departments throughout the year on their respective Operational Plans. The 2012 PCS format will be used in subsequent years with the intent to incorporate the results into the 2015 MCH BG Needs Assessment. See the PCS attachment.

In 2011, the Primary Care Office (PCO) collected data on the state's practicing medical, dental, and mental healthcare providers which will be used in the 2015 Needs Assessment. The PCO anticipates ongoing updates of this data as funding allows.

CSHS is preparing to apply for the 2012 State Implementation grant by conducting a comprehensive CYSHCN needs assessment by December 2011. The CSHS results will be incorporated into the 2015 MCH Needs Assessment.

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An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

PROCESS TO ESTABLISH TITLE V NEEDS AND PRIORITIES:

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The Title V Program functions within the Family and Community Health Bureau (FCHB) in the Public Health and Safety Division (PHSD) of Department of Public Health and Human Services (DPHHS). The Title V activities support Montana's MCH population issues and needs. Bureau activities include reviewing epidemiological data and information from stakeholder and public input activities, ensuring state and local staff are adequately trained in MCH program and policy development, development and implementation of evidence based programs and services addressing the health needs and risks impacting the MCH population, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V Program at both the operational and population health levels.

During FY2009, in preparation for the Maternal and Child Health Block Grant (MCH BG) application, Montana conducted an assessment of the health needs of women, infants, children, adolescents, and children with special health care needs in the state. The assessment consisted of various components including a review of subjective and objective data with state and local parties to ensure coordination of services. The assessment consisted of consumer input through focus groups, key stakeholder interviews, and professional judgment from those working in the field. The needs assessment process and resulting priority areas are more fully described in other sections and in the 2010 MCH Needs Assessment document, which is included with the 2011 application. The 2010 MCH Needs Assessment is a valuable tool for guiding the state's current and future MCH Block Grant applications.

Montana utilizes the Public Health System Improvement Taskforce (PHSI TF) as the advisory group which assists state staff to examine data and develop plans. The PHSI TF was created in 1993 and is responsible for implementing a statewide strategic plan for public health, developing policy recommendations and advocating for public health (PHSI TF Charter). The PHSI TF also serves as advisory for the preventive health block grant.

The FCHB's role in addressing these priority areas is through the major functions of public health, which are assessment, policy development and assurance. The Bureau may serve primarily to inform partners about the issue (assessment), may establish programs and services to address particular issues (policy development), and/or may work with public and private partners to facilitate access for the MCH population to needed services (assurance).

INTRODUCTION: Montana's geography, nature of her minority groups, political jurisdictions, economic characteristics, population size and distribution have a profound effect on the health of her citizens, how direct and public health services are provided, and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and 7 Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and has several state parks and state forest areas. The eastern two-thirds of the state are semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches.

ENVIRONMENTAL CONCERNS: Montana's environmental history includes extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues.

However, these extraction processes have left a legacy of environmental pollution. In 2010, Montana had 15 Federal Super Fund sites and 209 Comprehensive Environmental Cleanup Responsibility Act (CECRA) priority facilities . The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana Department of Public Health and Human Services (DPHHS) has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the Environmental Protection Agency (EPA) in 2010, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

POPULATION CHARACTERISTICS: The U.S. Census reports the 2009 population estimate to be 974,989, 44th in terms of population, with a population density of 6.6 people per square mile. The 2009 population estimates for Montana suggest an overall increase of 8.1% from 2000. The instate population has been redistributing to the western portion of the state and into urban areas over the last decade. The 2008 estimate projects that Montana has six counties with a population over 50,000 people and that 59% of Montanans reside in these six counties. The remainder of the population is dispersed into smaller communities, farms, and ranches . In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2009. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Anticipated population for 2030 is 1,044,898, ranking 27th in the nation for population growth .

AMERICAN INDIAN POPULATION: According to the 2008 Census estimate, there were 62,399 self-identified American Indians in Montana, or about 6.4 percent of the total population. Approximately 37,871 American Indians, or about 57.4 percent, lived on one of the state's seven reservations. The Blackfeet and the Flathead reservations were the largest, with 8,665 and 7,853 American Indian residents, respectively. Rocky Boy's (2,598) and the Fort Belknap (2,805) reservations were the smallest.

AGE: The median age in Montana for 2006-2008 was 39.3 years, higher than the national average of 36.7 years. 6.3% of the Montana population was under 5 years of age and 23% was under 18 years of age, compared to 6.9% and 24.5 % of the US population. Montana's population is split evenly between males and females. According to 2009 U.S. Census Bureau Estimates, women of reproductive age (15-44 years) comprise 17% of the state population .

ACADEMICS: Montana's graduation rate for public high school students for the 2005-2006 school year was 82% compared to the national average of 73%.

Mathematics, Grade 8--the percentage of students in Montana who performed at or above the National Assessment of Educational Progress (NAEP) Proficient level was 44 percent in 2009. This percentage was greater than that in 2007 (38 percent) and was greater than that in 1990 (27 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 82 percent in 2009. This percentage was greater than that in 2007 (79 percent) and was greater than that in 1990 (74 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of poverty, had an average score that was 22 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1996 (24 points). In 2009, the average mathematics score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 44 states/jurisdictions
- not significantly different from those in 5 states/jurisdictions

Reading, Grade 8-- The percentage of students in Montana who performed at or above the NAEP Proficient level was 38 percent in 2009. This percentage was not significantly different from that in

2007 (39 percent) and was not significantly different from that in 1998 (40 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 84 percent in 2009. This percentage was not significantly different from that in 2007 (85 percent) and was not significantly different from that in 1998 (83 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of low income, had an average score that was 14 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1998 (17 points). In 2009, the average score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 39 states/jurisdictions
- not significantly different from those in 10 states/jurisdictions

ETHNICITIES: Montana is predominately white with an estimated 90.5% of the 2008 population reporting Caucasian as the primary race, compared to 79.8% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.4% of the total population (62,399), the 5th highest state in the nation.

Census Population	2000	2009 Estimate
White	90.6%	90.5%
Black	0.1%	0.7%
American Indian	6.2%	6.4%
Asian	0.5%	0.6%
Native Hawaiian/ Other Pacific Islander	0.1%	
Two or more races		1.7%
Other	0.6%	

BIRTH & FERTILITY RATES: The Montana birth rate declined from the early 1980s to 1999. The rate of births to Montana residents leveled off and has increased in recent years. It grew to 13.2 per 1,000 residents in 2006 and fell just a bit in 2007 and 2008 to 13.0 . As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

In 2008, the fertility rate for Montana's white mothers of all ages was 66.2, the birth rate for white mothers between the ages of 15 and 17 was 14.5, and the rate for white mothers between the ages of 18 and 19 was 62.4. Fertility rates for Native Americans were substantially higher in these age groups--107.8, 55.1, and 188.3, respectively. American Indians account for about 6.4% of the total Montana population, and more than 12% of births.

Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites.

INDIAN HEALTH SERVICES, TRIBAL HEALTH ENTITIES & POLITICAL JURISDICTIONS: According to the U.S. Census Bureau designations, the state has 3 metropolitan areas (an urban population core of 50,000 or more) and 5 micropolitan areas (an urban population core of 10,000-49,999). However, the majority of the 56 counties are still considered rural or frontier. Fifty-four county health departments contracted with the DPHHS in FY 2010 to provide Maternal and Child Health (MCH) and other health services. The local health departments are county entities under the control of local Boards of Health and the staff are county employees. The seven Indian reservations are sovereign nations and home to 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems.

INDIAN RESERVATIONS and COORDINATION OF SERVICES: The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a continuing goal to increase the number of partnering reservations.

ECONOMIC ENVIRONMENT

MONTANA WAGES: Among the states with annual pay below the U.S. average, Montana posted the second lowest average pay ($33,305) in 2008. The lowest pay level was in South Dakota ($32,822). The next lowest pay levels were Mississippi ($33,508), Idaho ($33,897) and Arkansas ($34,919). The 2008 average annual pay figures for these states, which account for only 2.8 percent of the nation's workers, were 25 to 28 percent below the national average. Average annual pay levels for 36 states were below the U.S. average in 2008; combined, workers in these states accounted for 52 percent of the nation's covered employment .

FEDERAL AID: Montana taxpayers receive more federal funding per dollar of federal taxes paid compared to the average state. Per dollar of federal tax collected in 2005, Montana citizens received approximately $1.47 in the way of federal spending. This ranks the state 11th highest nationally and represents a rise from 1995 when Montana received $1.46 per dollar of taxes in federal spending (6th highest nationally). Resources supporting state level efforts for the MCH population, including Children & Youth with Special Healthcare Needs (CYSHCN), are overwhelmingly federal. Less than 5% of funding for the Public Health and Safety Division (PHSD), which houses the FCHB, is from the state general fund.

POVERTY: According to the U.S. Census Bureau's Current Population Survey, Montana's estimated poverty rate was 14.1% in 2007, which was above the national estimated poverty rate of 13.3%. Montana had the 16th highest poverty rate in the U.S. in 2007. From 2002 to 2007, Montana's poverty rate varied from a low of 13.6% in 2004 to a high of 14.6% in 2005. The percentage of near poor, those with incomes below 125%, 150% and 200% of the Federal poverty level, was higher in Montana than nationally. Montana counties reporting the highest poverty rates in 2007 include Roosevelt (30.3%), Glacier (26.6%) and Big Horn (26.4%). These three counties had poverty rates that were over 26%, with Roosevelt's rate (30.3%) being over twice as high as the state average (14.1%). Of the 56 counties in Montana, 36 of them held poverty rates above the national average of 13% in 2007. The lowest poverty rates were reported by Fallon (9.3%), Sweet Grass (9.4%) and Yellowstone (9.7%) Counties in 2007.

In 2007, about 15.7% of children under 18 years of age lived below the poverty line in Montana, while about 18% of the same age group lived below the poverty line in the U.S. About 13.2% of Montanans age 18 to 64 lived below the poverty line in 2007, while about 10.9% of this age group lived below the poverty line in the U.S. While 6.7% of individuals age 65 and over lived below the poverty line in Montana, about 9.7% of individuals age 65 and over lived below the poverty line in the U.S. in 2007.

AMERICAN INDIAN ECONOMIC CHARACTERISTICS: Health care and social assistance are the primary employers of American Indians in Montana. These two industries employ about 3,353 American Indians statewide. Public administration (which includes all forms of government) and educational services were second and third, employing 3,200 and 2,660 respectively. The median household income for American Indians was $22,824, far less than the $33,024 reported for all Montanan households. The median household income on the Crow Reservation was $28,199, compared to the $18,484 reported on the Fort Peck Reservation. A closer look at the figures reveals that the Crow Reservation reported by far the lowest percentage in the less than $10,000 income category. Furthermore, there were relatively more households on the Crow Reservation in the middle-income categories from $30,000 to $99,000. These households may

include people with relatively good-paying mining and Bureau of Indian Affairs (BIA) hospital jobs.

UNEMPLOYMENT: In 2009, Montana's unemployment rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2009 was 6.2%, compared to the U.S. rate of 9.3% . Unemployment on the reservations ranged from 8.5% to 16.3%, according to the 2009 Montana Reservation Labor Force Statistics. Data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

AMERICAN INDIAN UNEMPLOYMENT: Annual Average Unemployment Rates on Montana's Reservations

Reservations	2009
Blackfeet	13.8%
Crow	10.5%
Flathead	8.5%
Fort Belknap	Unavailable
Fort Peck	8.8%
Northern Cheyenne	14.0%
Rocky Boy's	16.3%

FACTORS IMPACTING THE MCH POPULATION

ORAL HEALTH: Eleven Montana Community Health Centers (Billings, Bozeman, Bullhook, Butte, Cutbank, Great Falls, Helena, Kalispell, Livingston, Missoula and Libby) include some dental services, though the waiting lists can be long.

Indian Health Service offers dental clinics in:

Browning (Blackfeet Service Unit [SU])	satellite in Heart Butte
Crow Agency (Crow SU)	satellites in Lodge Grass & Pryor
Lame Deer (Northern Cheyenne SU)	
Harlem (Fort Belknap SU)	satellite in Hayes
Poplar (Fort Peck SU)	satellite in Wolf Point
Tribal Programs:	
Box Elder (Rocky Boy SU)	
Polson (Flathead SU)	satellites in Pablo & St. Ignatius

Montana's point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) in 2002 reiterated lack of access to dental care for pregnant Medicaid participants as a statewide problem. In 2009, 11 counties did not have a dentist and 15 (including the 11) did not have a dentist that accepted Medicaid. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

IMMUNIZATIONS: In 2008, Montana had a 66% immunization rate for children aged 19-35 months who were fully immunized. In 2008, Montana ranked 50th in the nation for series of immunizations given to 19-35 month old children.

MORTALITY: (Rankings: 1=low, 51=high)
High mortality rates are a problem for Montana.

Infant Mortality
2004-2006: 6.0 per 1,000 live births

Death Rate for children aged 1-14 years
2006: 772.9 per 100,000

Five leading causes of death for MT children aged 1-14 years (2006):
1. unintentional injury (32.7%)
2. malignant neoplasms (14.3%)
3. homicide (6.1%)
4. congenital anomalies (4.1%)
5. suicide (4.1%), all others (38.8%)

Five leading causes of death for MT American Indian children aged 1-14 (2006):
1. unintentional injury (40%)
2. malignant neoplasms (20%)
3. suicide (20%)
4. all others (20%)
5. none listed

Death Rate for Total Population (all ages)
2006: 30 per 100,000

Five leading causes of death for total MT population (2006):
1. malignant neoplasms (22.9%)
2. heart disease (22.1%)
3. chronic low respiratory disease (6.8%)
4. unintentional injury (6.6%)
5. cerebrovascular (5.4%)
6. all others (36.1%)

Five leading causes of death for MT American Indian population--all ages (2006):
1. malignant neoplasms (19.9%)
2. heart disease (13.9)
3. unintentional injury (12.9%)
4. liver disease (6.1%)
5. diabetes mellitus (5.3%)
6. all others (41.8%)

In 2006, Montana had a suicide death rate of 19.7 per 100,000 in population.

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN): Montana had an estimated 27,853 children/youth with special health care needs in 2006, up somewhat from an estimated 26,981 in 2001. Examples of conditions that qualify children with special health needs in Montana are: cystic fibrosis, diabetes, cleft lip/palate, asthma, seizure disorder, and juvenile idiopathic arthritis. CYSHCN in Montana may be eligible to receive services from Children's Special Health Services (CSHS), DPHHS. The program's mission is to develop and support systems of care for CYSHCN. The following services are available to eligible CYSHCN and their families: pediatric specialty clinic services, financial assistance, and/or resource referrals. CSHS does not receive any general funds from the state of Montana, it is funded by the Maternal and Child Health Block Grant and revenue received from billing 26 health care agencies for three interdisciplinary clinics (cleft/craniofacial, metabolic and cystic fibrosis).

Effective January of 2008, all newborns are tested for hearing and the 28 conditions recommended by the American Academy of Pediatrics and the American College of Medical Genetics. The metabolic/bloodspot screen follow-up is a contracted service managed by CSHS. The newborn hearing screening program is managed by a staff member in CSHS. This staff person conducts on-site reviews for quality assurance and is continually assessing the needs of the families and partners of the newborn hearing program.

TOBACCO USE, MONTANA YOUTH:

In 2005, Montana introduced the Clean Indoor Air Act (CIAA) that was passed by the state legislature that required schools to be tobacco-free and public places to be smoke-free. The CIAA was fully implemented in October 1, 2009.
In 2009, 12% of high school youth who tried cigarettes before the age of 13, a 10% percentage point decrease from 2001 (29%). During 2009, the highest prevalence was reported for 9th grade students (18%) with the lowest prevalence reported for 12th grade students (8%) who tried cigarettes before the age of 13. Statewide, 50% of high school students had ever tried cigarette smoking (even one of two puffs) during 2009. The prevalence of high school youth who smoked cigarettes on at least one day during the past month decreased from 29% in 2001 to 19% in 2009. Cigarette use was more prevalent among females (20%) than males (18%) during 2009. The use of smokeless tobacco (e.g., chewing, sniffling, or dipping) among high school students decreased only slightly between from 16% in 2001 to 15% in 2009. In 2009, the use of smokeless tobacco was more prevalent among high school boys (24%) than high school girls (4%). In 2009, 55% of high school current smokers had tried to quit smoking cigarettes during the past 12 months.

In 2006, 38% of Montanans were aware that secondhand smoke is a risk factor for SIDS. In 2008, 97% of adults were aware that breathing secondhand tobacco smoke causes respiratory problems in children. Approximately 12% of Montana households with children permitted smoking at any time or any place in the home during 2008. In 2007, 30% of Montana children aged 12 to 17 years who lived in households where someone uses tobacco compared to 28% in 2003. Thirty-three percent of Montana high school students reported being in a car with someone who was smoking in 2008.

OBESITY: In 2007, 12% of Montana children aged 10-17 were obese compared to the national average of 16%. The obesity prevalence among Montana Youth increased over the past several years. The prevalence of obesity among Montana high school students increased significantly from 6% in 1999 to 10% in 2009. In 2009, high school girls had a lower prevalence of obesity (8%) compared to high school boys (13%). In 209, 24% of Montana adults were obese compared to the national average of 27%. The prevalence of obesity among Montana adults increased from 16% in 1999 to 24% in 2009. In 2009, females had a slightly lower prevalence of obesity (23%) compared to males (24%).

HEALTH CARE ACCESS
One Montana Critical Access Hospital CEO always began medical provider recruiting conversations with, "Our town is 70 miles from the nearest McDonald's, 90 miles from the nearest WalMart and 200 miles from the nearest shopping center. Can you handle that?" This description of an isolated Montana community is not unusual. A former Montana U.S. Senator put it this way, "There's a lot of dirt between light bulbs in Montana." Geographic isolation and the long distance between towns and healthcare organizations are often barriers to healthcare access in Montana.

Fifty-four percent of Montanans travel more than 5 miles (one way) to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles.

TRANSPORTATION: Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. With little or no public transportation available in Montana's many isolated, rural communities, access to local primary care as well as out-of-town specialty medical services can be a problem. Nearly 96% of Montanans drive themselves or get a ride from a friend when traveling to a doctor's office; fewer than 1% use public transportation (probably because public transportation is found primarily in urban areas and most of Montana is frontier or rural).

INCOME: Montana's lower-than-the-national-average median income adversely affects the

ability of many Montanans to pay for medical care. This is reflected in the 19.1% of Montana's population (nearly 180,000 people) without health insurance.

In a 2003 survey, 12.9% of Montana's adults reported they could not see a doctor in the previous 12 months because of the cost. Examining the survey a little closer, over a quarter (26.3%) of all Montana adults ages 18-64 with a disability--a population that probably needs to see a doctor regularly--had not seen a doctor in the previous 12 months because of cost. Also, over one-quarter (26.7%) of Montanans do not have a personal doctor or health care provider.

AVAILABILITY OF SERVICES: There are ongoing efforts towards the improvement of the availability of an access to health services in Montana. Montana has 45 Critical Access Hospitals, 17 hospitals, 46 rural health clinics, and 37 federally qualified health centers. There are also 56 local county public health health departments and 88 nursing home facilities in Montana. The state has 2353 licensed physicians, 599 active licensed dentists, and 81 psychiatrists.

Healthcare for American Indian residents of Montana is provided by a network of services including: Indian Health Service, hospitals/clinics, county health departments; and private health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte.

Because of its large geographic size and small population, Montana has 4.3 hospital beds per 1,000 people, ranking near the high end (47th out of 51) in beds-per-1,000-population compared to the 50 states and District of Columbia. However, Montana ranks low (19th out of 51) with 113 hospital admissions per 1,000 people. Montana ranks on the low end (40th out of 51) in the number of nursing homes in the state (again, because of its small population) and 44th out of 51 in the number of nursing home residents.
Although Montana has 76 home health agencies statewide, home health services are not available in 8 of Montana's 56 counties.

HEALTH INSURANCE: According to 2004 Center for Forensic Economic Studies (CFES) data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in Health Maintenance Organizations (HMO) in 2003, down from 2002.

In November 2008, Montana voters approved the new Healthy Montana Kids program, which expanded coverage under Medicaid and CHIP by raising eligibility levels to 133 percent and 250 percent of the federal poverty line, respectively. The expansion, which went into effect in October 2009, will cover as many as 29,000 of the 34,000 underinsured children in the state.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) STATUS 2010:
Montana continues to face a health care worker shortage. Since 2004, Montana has witnessed a net increase in the number of shortage designations. The active HPSA designations in Montana are:

Number of HPSA's in Montana

HPSA Type	2004	2007	2010
Primary Care	57	90	99
Dental Health	42	56	60
Mental Health	35	49	55

As of January 2010, Health Professional Shortage Areas, which included HPSA facilities, were located in all or parts of Montana's 56 Counties as follows:

- Primary Care: 55 out of 56 counties (98%)
- Dental Health: 48 of 56 counties (85%)
- Mental Health: 56 of 56 counties are designated all or in part as a shortage area.

CONCLUSION: As Montana's population continues to age, demand for all occupations -- including those that are now adequately staffed will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of its older-than-average population.

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The 2010 Needs Assessment resulted in the establishment of six Priority Areas and seven new State Performance Measures to better address the current needs of the MCH population. Montana's aging population, geographic challenges, and access to care issues all pose unique challenges to health care delivery for the MCH population. In some counties, local health departments are the sole source of health care for the surrounding population. Montana's Title V funds, which directly support the local health departments in 54 of 56 counties, are critical to meeting the public health needs of the MCH population across the state.

REFERENCES

State of Montana. CECRA Priority Sites Sorted by Site [Web Page]. http://www.deq.mt.gov/StateSuperfund/PDFs/CecraListBySite.pdf Updated January 26, 2010. Accessed April 16, 2010.

U.S. Census Bureau. State & County QuickFacts [Web page]. http://quickfacts.census.gov/qfd/states/30000.html Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Estimates for Montana Counties [Web page]. http://quickfacts.census.gov/qfd/states/30000lk.html Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

http://factfinder.census.gov/servlet/GRTTable?_bm=y&-_source=mdr&-geo_id=01000US&-_col=disp_order&-ds_name=ACS_2005_EST_G00_&-_lang=en&-redoLog=false&-mt_name=ACS_2005_EST_G00_R0101_US30&-format=US-30

U.S. Census Bureau. State & County QuickFacts: Population Projections to 2030 [Web page]. http://www.census.gov/population/projections/SummaryTabA1.pdf Accessed May 2, 2010.

U.S. Department of Education, Institute of Education Sciences. National Center for Educational Statistics: Public High School Graduation Rates by State [Web page]. http://nces.ed.gov/programs/coe/2009/section3/indicator19.asp Accessed May 1, 2010.

U.S. Department of Education, Institute of Education Sciences. National Center for Educational Statistics: State Profiles [Web page]. http://nces.ed.gov/nationsreportcard/states/ Accessed May 1, 2010.

U.S. Census Bureau. State & County QuickFacts [Web page]. http://quickfacts.census.gov/qfd/states/30000.html Accessed May 2, 2010.

State of Montana, Department of Public Health and Human Services. Natality [Web page]. http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2008report/08birth.pdf#fig1 Accessed

May 1, 2010.
State of Montana, Department of Public Health and Human Services. Natality [Web page]. http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2008report/08birth.pdf#fig1 Accessed May 1, 2010
2008 Quarterly Census of Employment and Wages, U.S. Bureau of Labor Statistics
Tax Foundation. Tax Data, Charts, and Maps [Webpage]. http://www.taxfoundation.org/taxdata/topic/40.html Accessed May 3, 2010.
Montana State University. Montana's Poverty Report Card [Webpage]. http://www.montana.edu/extensionecon/poverty.html Updated June 2009. Accessed May 3, 2010.
Montana State University. Montana's Poverty Report Card [Webpage]. http://www.montana.edu/extensionecon/poverty.html Updated June 2009. Accessed May 3, 2010.
State of Montana, Tribal Reports and Data. Economic Status of American Indians in Montana: A Preliminary Assessment [Webpage]. http://tribalnations.mt.gov/trreports.asp Updated Winter 2004. Accessed April 30, 2010.
United States Department of Labor, Bureau of Labor Statistics. Unemployment Rates for States [Webpage]. http://www.bls.gov/lau/lastrk09.htm Accessed May 4, 2010.
State of Montana. Montana Reservation Labor Force Statistics 2008 Annual [Webpage]. http://www.ourfactsyourfuture.org/cgi/databrowsing/?PAGEID=4&SUBID=220 Accessed May 4, 2010.
The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=54&cat=2 Accessed May 6, 2010.
The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=667&cat=2 Accessed May 6, 2010.
Centers for Disease Control. National Center for Injury Prevention and Control [Webpage]. http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html Accessed May 6, 2010.
The Henry J. Kaiser Family Foundation. State Health Facts [Webpage]. http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=667&cat=2 Accessed May 6, 2010.
Health Resources and Services Administration: The National Survey of Children with Special Health Care Needs 2005-2006 [Webpage]. http://mchb.hrsa.gov/cshcn05/SD/montana.htm Accessed June 30, 2010.
Tobacco Free Montana. Trends in Youth Tobacco Use and Attitudes 2000-2006 [Webpage]. http://tobaccofree.mt.gov/publications/youthtrends20002006.pdf Accessed May 7, 2010.
From Larry Putnam, retired CEO, Phillips County Medical Center, Malta, Montana

Senator Conrad Burns, U.S. Senate Floor, December 8, 2004

2005 BRFSS Data: State Added Question, "Travel Access To Health Provider"

Ibid.

2004 BRFSS Data

Ibid.

See "Beds per 1,000 population" table, The Henry J. Kaiser Family Foundation. http://www.statehealthfacts.org/comparetable.jsp?ind=396&cat=8&sub=95&yr=1&typ=1&sort=1238

See "Admissions per 1,000 population" table, The Henry J. Kaiser Family Foundation. http://www.statehealthfacts.org/comparetable.jsp?ind=398&cat=8&sub=95&yr=1&typ=1&sort=1238

See "Total Number of Certified Nursing Facilities, 2006", The Henry J. Kaiser Family Foundation.

http://statehealthfacts.org/comparetable.jsp?ind=411&cat=8&sub=97&yr=17&typ=1&sort=n&o=d

See "Total Number of Residents in Certified Nursing Facilities, 2006", The Henry J. Kaiser Family foundation.
http://statehealthfacts.org/comparetable.jsp?ind=408&cat=8&sub=97&yr=17&typ=1&o=d&sort=n

From 2004 Montana County Health Profiles. See http://nris.mt.gov/epht/hra.aspx?county=30000&year=2004. The eight counties without home health services are Big Horn, Carter, Golden Valley, Musselshell, Petroleum, Treasure, Valley and Wheatland.

/2012/According to 2010 Census data, Montana saw an increase in total population to 989,415; a slight decline from 6.4 % to 6.3% in the number of American Indian and Alaska Native persons residing in Montana, and slight changes in the racial composition: White persons 89.4%; Black persons, 0.4%; American Indian and Alaska Native persons, 6.3%; Asian persons, 0.6%; Native Hawaiian and Other Pacific Islander, 0.1%; persons reporting two or more races, 2.5%

In SY 2011, the Northern Cheyenne Tribal Health Department elected to not renew their Public Health Home Visiting (PHHV) contract, resulting in PHHV being offered by the Rocky Boy/Chippewa Cree Tribal Health Department and by 14 county health departments.

In SFY 2009, Healthy Montana Kids (CHIP) had 25,298 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

State funding remains about 5% of the Public Health and Safety Division's total budget. The 2011 legislature's decision to cut the Montana Tobacco Use Prevention Program (MTUPP) funding in half from 8 million to 4 million will significantly reduce MTUPP's ability to fund outreach to specific populations such as those covered by MCH. A few noticeable reductions will be in cessation benefits available, training for home health nurses, outreach to low socioeconomic status groups, and the policy work for smoke free housing. The FCHB and MTUPP partnership will remain; however, it is unknown at this time, the budget cut's impact on MTUPPs availability for providing smoking cessation training to the PHHV and MIECHV Home Visiting programs.

The attached map illustrates FY 2012 MCH services. //2012//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Montana's Title V programs are located in the Department of Public Health and Human Services (DPHHS), the largest agency of Montana's state government, with a biennial budget of about $3 billion. DPHHS has 3,100 employees across the state of Montana, 2,500 contracts and 150 health programs. The programs are housed in one of the 11 divisions of DPHHS. The Title V Program is housed in the Family and Community Health Bureau (FCHB) which is within the Public Health and Safety Division (PHSD), one of the 11 divisions of DPHSS. The FCHB is charged with the responsibility of administrative oversight of the Title V Maternal and Child Health Block Grant (MCH BG). This responsibility includes developing and sustaining collaborative public and private partnerships for the purposes of providing maternal and child health care services to Montana's MCH population across Montana's 145,552 square miles, 56 counties, and 7 Native American reservations.

Statutory Authority for Maternal and Child Health (MCH) Services are found in the Montana

Codes Annotated (MCA 50-1-2020). General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Fetal, Infant, Child, Mortality Review (FICMR) are authorized in Title 50.

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women.

The FCHB has a role in ensuring that services and programs to support healthy growth and development are available and accessible to Montana's MCH population. The Bureau budget includes 13 funding sources, of which approximately 96% is federal funding and the remaining 4% is state general fund. The three largest funding sources are from the United States Department of Agriculture for WIC Administration and Supplemental Food; the Department of Health and Human Services Maternal and Child Health Block Grant; and the Office of Population Affairs Title X Family Planning. Additional federal grants, earmarked for specific programs benefitting the MCH population, round out the FCHB yearly operating budget.

Montana's economic situation is similar to that of the other states: a decline in state revenue has resulted in budget cuts for programs allocated state general dollars. The decline in state general revenue as well as the loss of federal funding to support programs (such as the coordinated school health program, the birth defects registry from CDC, the oral health program from HRSA, and the fetal alcohol spectrum disorder prevention program funding from SAMHSA) contributed to diminished FCHB staff and a subsequent reorganization. In May, 2010 the Infant Child Maternal Health Section was combined with the Maternal Child Health Coordination Section, decreasing the number of supervisory staff by one. The Primary Care Office, Public Health Home Visiting Program, FICMR and Targeted Case Management support functions were moved along with 2.5 FTE staff positions into the MCHC Section. In addition, PHSD leadership created an office of Epidemiology and Scientific Support, which will be led by the State Epidemiologist who is presently being recruited. One of the two MCH epidemiologists is moving to the new office of Epidemiology and Scientific Support. The remaining MCH epidemiologist will continue to focus on MCH issues.

As of May 2010, the 36 staff members of FCHB are organized into four sections, one unit, and one office:

- Maternal Child Health Coordination Section (MCHC),
- Children with Special Health Services Section (CSHS),
- WIC Nutrition Section (WIC),
- Women's and Men's Health Section (WMH),
- MCH Epidemiology Unit, and the
- Primary Care Office.

The FCHB is responsible for coordinating the ongoing MCH Needs Assessment process. Included with this application, is Montana's 2010 MCH Needs Assessment, which is a culmination of the past five years of numerous meetings with public and private partners; gathering qualitative and quantitative data; analyzing the data; identifying MCH priority needs, (as well as emerging needs); assessing the State's current resources, activities, and services; and developing state performance measures based on the FCHB's capacity to provide direct health care services, population based services, enabling services, and infrastructure-building services.

In addition to ensuring the ongoing work on the MCH Needs Assessment, each FCHB section

fulfills a role as related to the requirements for receiving the MCH BG. As illustrated on the Agency Capacity Attachment, each section maintains numerous partnerships with public and private entities, which provide preventive and primary care services to the MCH population.

The MCHC Section's primary partners for MCH services are Montana's county health departments. Montana's MCH Administrative Rules of Montana (ARM 37.57.1001) do not require county health departments to accept the MCH Block Grant funding, they can choose to not participate. In FY 2010, 54 of Montana's 56 county health departments accepted MCH funding with the intent of providing MCH services to their populations; two counties opted to not contract with the state to provide MCH services. As part of their contractual obligations, the contracted county health departments select one national or state performance which will be their primary MCH focus. Approximately 42% of the state's MCH BG allocation is distributed to the local health departments.

The MCHC Section also houses the Public Health Home Visiting (PHHV)/ Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Program. The PHHV program is part of the MIAMI act passed by the Montana legislature in 1989. The Legislature has continued to support the PHHV/MIAMI Program with general funds and tobacco trust settlement moneys. The goals of the MIAMI legislation compliment the charges in Title V of the Social Security Act, which are to: 1) ensure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services; 2) reduce the incidence of infant mortality and the number of low birth weight babies; and 3) prevent the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care.

The PHHV/MIAMI Program has continued to evolve to meet the needs of the MCH population. In Fiscal Year 2010, 14 county health and two tribal health departments provided PHHV services by using a team consisting of a public health nurse, social worker, and dietitian, to provide support and guidance to families who may not be able to access services. Most recently, the PHHV/MIAMI contractors and FCHB staff completed a PHHV reassessment collaborative process whereby changes were recommended to the program requirements. For Fiscal Year 2011, the PHHV/MIAMI contractors will be required to address four outcome measures, which are directly related to the MCH BG: 1) increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index; 2) increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 3) increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams); and 4) increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

The FCHB has been selected to provide the leadership and administrative oversight for the state's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program grant applications. Phase I was submitted on July 9, 2010. and Phase II will be submitted on September 20, 2010. The Bureau has engaged in several stakeholder meetings with the Directors of Montana's agency for Child Abuse Prevention and Treatment, Substance Abuse Services, Head Start State Collaboration Office, and Early Childhood Services as well as with other interested stakeholders that are currently providing home visiting services. These meetings have aided in the state's Phase II application and have laid the foundation for the final phase of implementing the ACA Home Visiting grant in Montana.

The Fetal, Infant and Child Mortality Review Program (FICMR) is also housed in the MCHC Section. FICMR is a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on multidisciplinary reviews of the deaths. These in-depth reviews bring together a variety of information from many sources and provide a venue for communities to recognize system shortcomings and create strategies to improve these systems. The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility that was authorized in statute (MCA 50-19-401 through 50-19-406) in

1997. The FICMR process identifies critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes. In 2005-2006, 53 of Montana's 56 counties and all 7 Indian Reservations participated in FICMR reviews through 30 local FICMR teams. To date, 89% of fetal, infant and child deaths in Montana in 2005-2006 have been reviewed by local teams. A biennial report is prepared and distributed to policy makers. Policy makers review preventable deaths and strategize at community and state levels on how to address FICMR related issues.

To the extent resources allow, the MCHC also addresses the MCH population's oral health needs. One of the two MCHC Health Education Specialists oversees the Open Wide Program, a free online training program initially developed by the National Maternal & Child Health Resource Center, which is accessible to providers who work with the MCH population, i.e. Head Start and child care providers; WIC; public health departments; and school nurses. Montana's Oral Health Education guide was recently highlighted in the National Maternal & Child Health Resource Center, March 2010, Oral Health Resource Bulletin.
The MCHC Supervisor collaborates with the Early Childhood Services Bureau (ECSB), housed in the Human and Community Services Division, who administers the Early Childhood Comprehensive Systems Initiative Grant (ECCS). The ECCS Grant has supported the development and training on a Parent Education and Leadership Curriculum; implementing an early childhood mental health consultation model in child care programs; and ongoing support for 18 Community School Readiness Teams. The MCHC Section also ensures the collaborations and partnerships for addressing those national performance measures which are housed in other Departments. These partnerships include working with the State's Suicide Prevention Coordinator, the Injury Prevention and Immunization Sections, and Healthy MT Kids which operates the MCH toll-free line.

Montana's Children and Youth with Special Health Care Needs (CYSHCN) and their families are served by a number of programs that emanate from the Children's Special Health Services (CSHS) Section, which rejoined the FCHB in January, 2006. Prior to 2006, CSHS was located in the Health Care Resources Bureau of the Health Resources Division. Montana is unique in that blind and disabled individuals, under the age of 16 are automatically eligible for benefits under Title XVI. These individuals are also eligible to receive CSHS services.

Data taken from Montana's 2004 - 2008 MCH Block Grant Annual Reports indicates an average of 4,698 CYSHCN received services from a number of programs overseen by the CSHS. CSHS is responsible for system development and service support for children and youth with special health care needs and their families. This section provides regional clinics, direct pay programs, the newborn hearing and metabolic screening programs, and coordination of the state's genetics program.

CSHS works closely with three Regional Pediatric Specialty Clinics (RPSC) which provide medical care for CYSHCN. The RPSC are in Great Falls, Missoula, and Billings, and outreach clinics are conducted in Bozeman, Helena, and Kalispell as well as on two reservations: Wolf Point and Browning. There are three interdisciplinary clinics: cleft/craniofacial, cystic fibrosis and metabolic. The pediatric specialty clinics vary by region, but include: endocrine, genetics, gastrointestinal, hemophilia, high risk infant, muscular dystrophy, neural tube defect, orthopedic, pulmonary, rehabilitation, and rheumatology.

The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking. CSHS continues to support the development of Children's Health Referral and Information System (CHRIS), a data collection system that is interconnected with the RPSC, MT School for the Deaf and Blind, the MT Medical Genetics program, Healthy MT Kids, Social Security Disability, neonatal intensive-care unit (NICU) referrals, outreach specialty providers and others.

January 2008 witnessed the beginning of the implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards. CSHS has developed and maintained a partnership with the Department's Laboratory Services Bureau which houses the Newborn Screening Coordinator position. CSHS continues to provide the leadership and administrative oversight of the Newborn Screening Follow-Up Program which is contracted with Shodair Children's Hospital.

Throughout the years, the CSHS staff has focused their efforts to secure Healthy MT Kids (formerly known as CHIP) and Healthy MT Kids Plus (formerly known as Medicaid), and private insurance payments for services provided at their regional clinics, with the revenue being reinvested in the CSHS programs and services. A portion of these funds is used to ensure that patients who are uninsured or under-insured are able to attend the interdisciplinary clinics and that they are not charged. CSHS does not collect co-pays or deductibles from patients attending CSHS interdisciplinary clinics.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Their work with Parents Lets Unite for Kids (PLUK), a longstanding advocate for parents and families and the host organization for Montana's Family Voices chapter, centers on collaboration to improve access to community-based, family-centered services for CYSHCN. CSHS also works closely with the entity providing Part C Services, the School for the Deaf and Blind, Social Security Disability, NICUs, school nurses, Vocation Rehabilitation, and the chronic disease program within DPHHS. CSHS also works with case managers from hospitals (in and out of state), insurance companies, and counties.

The FCHB is home to the state's Title X Agency, the Women's and Men's Health Section (WMH) that has historically received a small portion of MCH Block Grant funds to support their partnerships with 14 Delegate Agencies (DA) offering family planning services in 28 locations serving all 56 counties. WMH is responsible for family planning services through Title X supported clinics across the state. The section also monitors and supports community based efforts to prevent teen and other unintended pregnancies.

In FY 2011, WMH will receive $10,000 for their distribution to the DAs for their efforts aimed at preventing teen pregnancies. The DAs provide reproductive health services, technical assistance, and educational and outreach materials targeting low income women and men, including adolescents.

The DAs are also a designated Sexually Transmitted Disease (STD) Program working closely with the Division's STD/HIV Prevention Section. Additionally, each DA is required to employ a medical service provider who provides comprehensive breast and cervical screening services to an identified target population, as well as provide referral services to other programs, i.e. WIC.

Also housed in the FCHB is Montana's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Section. WIC administers the WIC program in Montana, which offers services through 27 Regional Program contracts with Public Health Departments, hospitals, private non-profits, and tribal organizations with related health or social service programs providing services for all counties in Montana. In 2007, an average of 21, 000 participants per month were provided nutrition assessment and education to improve their eating behaviors; referrals to other health care and social service programs; access to a supplemental food package which now includes fresh fruits and vegetables; and breastfeeding encouragement.

Beginning in 2009, WIC has been involved with developing, implementing, and offering training on MSPIRIT, a new MIS (management implementation system for WIC). It is anticipated that MSPIRIT will provide enhanced data as to the numbers of women initiating breastfeeding, as well as continuing to breastfeed at six months of age and beyond as MSPIRIT links the breastfeeding dyad and food packages being issued. MSPIRIT will also provide data as to the usage of Montana's new WIC Food Package that was rolled out in November 2009. WIC is also the lead

for breastfeeding promotion programs through their oversight of the Breastfeeding Peer Counselor Projects (BPCP). Nine Montana communities were funded and operated throughout the year as a BPCP.

WIC also supports the USDA WIC Farmer's Market Nutrition Program (FMNP), which has been operating in Montana since 2002. FMNP participants receive nutrition education related to fruits and vegetables. The nutrition education includes information on selecting, preparing, best time to buy and nutritional value of fruits and vegetables, and the value of physical activity for a family by shopping at their local farmers' market. In 2007, there were seven local WIC programs participating in FMNP: Custer, Flathead, Lewis and Clark, Missoula, Ravalli, Valley and Yellowstone. The WIC FMNP benefits allow participants to purchase locally grown fresh fruits and vegetables. A total of 5,354 women and children were provided the benefit of $16 in FMNP checks for the market season. Participant and farmer responses to the program have been positive.
The MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant, overseeing the 2010 MCH Block Grant Needs Assessment, and submitting the FCHB's Graduate Student Internship Program application, is integral to the FCHB. As mentioned earlier, the PHSD reorganization, upon the hiring of the state Epidemiologist, will result in the present Epidemiology Unit housing the lead MCH Epidemiologist and the FCHB Data Coordinator. Both these positions work closely with the four sections advising on and conducting epidemiological analyses and evaluation projects for the programs administered by the sections. The Epidemiology Unit provides key services for additional grant opportunities that are submitted by the FCHB, and will be a key player in the state's ACA Home Visiting application.

The Primary Care Office (PCO) was incorporated into the MCHC Section in 2009, but continues to operate as a unique program within the Bureau. The Primary Care Office's responsibilities focus on facilitating federal designation of health professional shortage areas, and supporting recruitment efforts for primary care, oral health and mental health professionals. The PCO compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state. The PCO and Epidemiology Units provided critical data for the state's April 2010 Grants to States to Support Oral Health Workforce Activities, that if funded will move Montana forward by hiring an external evaluator to perform a thorough assessment of the oral health status and needs of the state and expand the MT Area Health Education Center (AHEC) dental recruitment and retention program.

Maternal and child health services are funded not only by the MCH Block Grant distributed to counties, but by local funding, fees and donations and through programs supported with state general funds. As reported in Montana's MCH BG Annual Reports for 2004 - 2009, direct health care, enabling, population based, and infrastructure services were provided to an average of 97,007 clients per year. As reported in Montana's MCH Block Grant 2008 Annual Report, state funding for genetics, home visiting, and newborn screening follow up resulted in a total state match of $2,173,902. In addition, local partners, primarily local health departments, provided additional match of $3,500,746, and program income (including state and local billing and donations) which totaled $914,508. These amounts, combined with the 2008 federal allocation of $2,462,222 totaled $9,051,378 for MCH Services.

The MCH Block Grant data collected by the FCHB indicates that Montana continues to spend the largest portion of funding on children's services, primarily through contracts with local agencies that in turn provide preventive and primary care services for pregnant women, mothers, infants, and children. The local contractors provide:

- Enabling services, such as health education; family support; assistance with enrollment into Healthy MT Kids or Healthy MT Kids Plus (formerly CHIP and Medicaid); and case management;
- Population-based services such as newborn screening and neonatal follow-up; oral health education; public education on preventable deaths; and immunizations; and
- Infrastructure services such as technical assistance for developing standards of care,

evaluation procedures, and policy development; and training opportunities at the annual DPHHS Spring Public Health Conference.

The CSHS programs and services for CYSHCN expend 30% of the MCH Block Grant. These services are primarily direct health care services such as the medical services provided at the Regional Pediatric Specialty Clinics and the purchase of medical equipment not covered by insurance.

The Governor's Office provides an annual Tribal Relations Training for state employees to strengthen government-to-government relationships and to ensure that participants have a better understanding of state-tribal policies and principles to integrate into their day-to-day work with tribal governments and people. All FCHB Section Supervisors, as well as several other FCHB staff, have attended this training in the last three years. Recently, the Governor's Office also developed an online training program, designed by the federal government, entitled "Working Effectively with Tribal Governments." The training curriculum has been developed to provide government employees with skills and knowledge they can use to work more effectively with tribal governments.

The FCHB organizes and promotes a yearly Spring Public Health Conference. The planning committee has made it a priority for the opening ceremony to be provided by one of the seven Native American tribes in Montana. The Conference also strives to include at least one breakout session which focuses on health concerns associated with Native Americans.

The role of the Health Resources Division (HRD) is to provide health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan. The HRD provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program. It also provides children's mental health services and health insurance coverage for children through CHIP.

The FCHB's vision is to promote high quality health care services that are delivered in a respectful manner; promote healthy and safe Montana environments (family homes, child care facilities, schools, and communities), and reduce health care disparities within the state. Its mission is "to promote and improve the health and safety of Montana's women, men, children, and families." The FCHB is able to achieve its vision and mission through its ongoing administration of the Maternal Child Health Block Grant and the much needed services this funding provides to the state's maternal child health population.

/2012/Denise Higgins began as Bureau Chief for the Family and Community Health Bureau (FCHB) in December 2010. In February 2011, the FCHB began a series of monthly strategic planning and communication building meetings with the goal of developing a more cohesive bureau responsive to the needs of the Bureau's customers, which include county and tribal health departments, community based organizations, and other governmental agencies within and outside of the Department of Public Health and Human Services.

In the past year, the Public Health and Safety Division (PHSD) added the Office of Epidemiology and Scientific Support, which includes epidemiologists from each of the five Bureaus within the PHSD. The Family and Community Health Bureau's Maternal and Child Health Epidemiology Unit consists of two positions: the Lead MCH Epidemiologist and the Data Coordinator. As of July 2011, the FCHB consists of 35 staff members, with one position vacancy in the Maternal and Child Health Coordination (MCHC) Section, WIC, and the MCH Epidemiology Unit. See the FCHB Organizational Chart attachment in the Organizational Structure Section.

As noted in 2011, the MCHC section within FCHB was designated as the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting (ACA MIECHV) grant administrator. The subsequent required ACA MIECHV grant applications for continued

funding have been submitted to HRSA. The Maternal and Child Health Epidemiology Unit provides support and technical assistance for the ACA MIECHV particularly around the benchmark and construct measures and the continuous quality improvement activities.

Additionally, the MCHC Section submitted an application for one of the ACA MIECHV Development Grants (HRSA 11-179) on July 1, 2011. It is anticipated that the MCHC position vacancy will be advertised with the intent to hire an individual to be responsible for the ACA MIECHV projects. This position would work closely with the Public Health Home Visiting (PHHV) Nurse Consultant who provides oversight to the state's PHHV program, a non evidence based model. In SY 2011, one of the two tribal health departments providing PHHV services declined funds, resulting in PHHV being offered through 14 county and one tribal health departments.

In September 2010, the MCHC filled the position for the State FICMR Coordinator. Also in September, the MCHC received the Notice of Grant Award for the Grants to States to Support Oral Healthcare Workforce Activities. The Primary Care Office will apply for the State Primary Care Offices Retention and Evaluation Activities Under the American Recovery and Reinvestment Act Grant (HRSA 11-201) due August 2011.

The WIC program completed the roll out of M-SPIRIT to all local agencies in January 2010. The system has helped to improve and track services provided by WIC. State staff continues to work with the SPIRIT Users Group to enhance the system to make sure it meets all of the program needs as changes are made in the WIC Program. Data from the system is now able to be used to make program projections and decisions.

In October of 2010 WIC initiated a yearlong outreach project which included statewide bill boards, radio and television advertisements. MT WIC also received a facelift and was rebranded. They developed a new WIC logo and all participant printed materials were redeveloped and distributed to local agencies for use. MT Farm Direct was developed so that the new fruit and vegetable benefits and FMNP benefits could be used at farm stands and farmers markets all across the state. A promotion of "What Incredible Choices" Tool Kit was provided to all Local WIC Agencies to provide ideas and materials for providing education about fruits and vegetables.

MT WIC is completing the planning phase for the transition to EBT from paper benefits. Total implementation is targeted for 2013.

CSHS requested that the Medicaid program conduct a review of non-covered medically necessary items such as over-the-counter vitamins, food thickeners and hypertonic saline, which by is covered by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In the coming year, discussions will continue as to how Medicaid can pay when there is no rebate agreement in place for such items. CSHS will continue exploring opportunities to provide additional nutritional services to clients in the regional areas. CSHS is preparing to apply for the 2012 State Implementation grant by conducting a comprehensive CYSHCN needs assessment by December 2011.

Data from Federal Fiscal Year 2010 collected in Child Health Referral and Information System (CHRIS) shows 5529 children and youth with special health care needs received services from the CSHS Section.

The Women's and Men's Health Section filled their Health Education Specialist position in September 2010. As of July 1, 2011, there are now 26 locations with family planning services serving women from all 56 counties. //2012//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director of the Department is Anna Whiting Sorrell, who was appointed by Governor Brian Schweitzer in November 2008. She oversees the agency's 3,100 employees, 2,500 contracts and 150 programs. DPHHS is the largest agency of state government, with a biennial budget of about $3 billion.

The Department of Public Health and Human Services (DPHHS) is a "mega agency" encompassing health and human services for the state of Montana. The Department is organized into the Director's Office and 11 divisions. The Director's Office includes offices responsible for legal affairs, human resources, public information, planning and analysis.

The rest of the Department is organized into 11 divisions:

- Addictive & Mental Disorders -- Develops and implements a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.
- Business & Financial Services - Provides professional services for the management of the Montana Department of Public Health and Human Services.
- Child & Family Services -- Provides services to protect children who have been or are at substantial risk of abuse, neglect or abandonment.
- Child Support Enforcement - Pursues and finances medical support of children by establishing, enforcing, and increasing public awareness of parental obligations.
- Developmental Services - Contracts with private, non-profit corporations to provide services for individuals, and their families, who have developmental disabilities.
- Health Resources - Provides health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan.
- Human & Community Services - Provides cash assistance, employment training, supplemental nutrition assistance (formerly food stamps), Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services for needy families.
- Quality Assurance - Monitors and ensures the integrity and cost-effectiveness of programs administered by the department.
- Senior & Long Term Care - Provides information, education, and high quality, cost effective long-term care services for the elderly and disabled.
- Technology Services - Provides operational and technical support to department programs.
- Public Health & Safety -- see below

Jane Smilie is the administrator of the Public Health and Safety Division. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The state's public health system is a complex, multi-faceted enterprise, including partners such as the City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The Division is organized into five bureaus:

- Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
- Communicable Disease & Prevention Bureau -- Jim Murphy, Bureau Chief
- Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
- Laboratory Services Bureau - Anne Weber , Bureau Chief
- Family and Community Health Bureau -- Jo Ann Dotson, Bureau Chief

Maternal and child health services, as described in the Title V of the Social Security Act, are the responsibility of the Family and Community Health Bureau (FCHB). The Family and Community

Health Bureau has a staff of 36 and a total budget of approximately $22 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

- Maternal Child Health Coordination -- Ann Buss, Supervisor
- Children's Special Health Services -- Denise Brunett, Supervisor
- WIC/Nutrition -- Joan Bowsher, Supervisor
- Women's and Men's Health -- Colleen Lindsay, Supervisor

The Bureau also has an MCH Epidemiology Unit, led by Dianna Frick, and the Primary Care Office, led by John Schroeck.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.mt.gov/orgcharts/bureauorgchart.pdf. Organizational charts for the Public Health and Safety Division and the Family and Community Health Bureau are attached as a single document.

/2012/As noted in the updates for Section B: Agency Capacity and Section D: Other MCH Capacity, the FCHB experienced changes in staffing. The MCH Epidemiology Unit consists of the Lead MCH Epidemiologist and FCHB Data Coordinator, a position that is currently vacant. In December 2010 Denise Higgins began as the Bureau Chief for the FCHB. An updated FCHB Organizational Chart is included as an attachment.

The FCHB total federal FY 2012 budget is approximately $25.5 Million, a $3 million increase. Additional federal funding includes the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting, an increase for WIC's SPIRIT project and a reallocation of funds to the WIC Breastfeeding Peer Counseling project, and the Grants to States to Support Oral Health Workforce Activities.

The FCHB manages 134 contracts for FY 2012, the majority being contracts with local health departments and clinical services.

The 2011 Legislative session approved the Public Health and Safety Division 2013biennial budget request at approximately $3.1 million or 2.4% less when compared to the 2011 biennium. For more information go to: http://leg.mt.gov/css/fiscal/reports/2011-session.asp#ba2013

Information about the Department of Public Health and Human Services can be accessed at: http://www.dphhs.mt.gov/
//2012//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The MCH BG supports 13.5 FTE at the state level in FFY 2010. Staff supported by the MCH BG are located in the MCHC and CSHS Sections, and in the MCH Epidemiology Unit. The Bureau Chief's salary is cost allocated to all programs and sections, based on the number of staff in the program. Other funding sources supporting staff in the FCHB include other federal funds (WIC, Title X, Newborn Hearing Screening and SSDI) and some general fund and state special revenues.

Key Title V staff in Montana include:

Jo Ann Walsh Dotson, RN, PhD -- Bureau Chief. Dr. Dotson has been the Bureau Chief of the FCHB since December of 1997. Dr. Dotson was an inpatient and outpatient pediatric nurse, and a faculty member in the College of Nursing at Montana State University prior to working for the state. Dr. Dotson's 2009 dissertation evaluated the home visiting program in Montana. Dr. Dotson is retiring from state government in the summer of 2010 -- the position will be recruited with a target start date of fall of 2010. On July 1, 2010 Joan Bowsher, WIC Director, was appointed as Acting Bureau Chief for the FCHB.

Ann Buss, MPA -- MCHC Supervisor. Ms. Buss has been the MCHC supervisor since 2006. She oversees seven staff responsible for general MCH service contract support, public health home visiting, oral health promotion, primary care recruitment and retention and bureau financial and administrative support. Ms. Buss completed her MPA in 2008 and the MCH Certificate program through RMPCH in 2009. She is a member of the Directors' Strategic Planning Committee, and represents the division on the Interagency Coordinating Council for Women. Ms. Buss is also a member of the Legislative and Finance Committee of AMCHP.

Denise Brunett, BA -- CSHS Supervisor. Ms. Brunett has been the CSHS supervisor for two years. She oversees five staff and a contracted staff member responsible for the newborn screening and genetic programs, the regional clinics and CYSHCN referral services. Ms. Brunett represents the division on the HIPAA workgroup

Dianna Frick, MPH -- Lead MCH Epidemiologist Ms. Frick has led the Epidemiology Unit for two years. Ms. Frick has routine meetings with the medical officer who also serves as the state epidemiologist; a new position for a state epidemiologist was created and is presently being recruited to oversee a new Division level office of Epidemiology. One of the two MCH Epidemiologists, Dorota Carpenedo, is being moved to the new office once the lead position is filled. Ongoing coordination of the work of the MCH epidemiology unit with the new office will be needed over the coming years.

Montana CSHS has a CSH Committee that according to its charter, provides crucial input to the program regarding family concerns and needs. On this committee are three parents of children with special health care needs. At this time their involvement has been their attendance at committee meetings. The CSHS manager will continue to encourage as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2)

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated; cost allocation has increased annually for the last several years. In addition, administrative rule and MCH Service contracts allow county health departments to use up to 10% of the funds allocated to them for administrative purposes.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. Approximately 41% of the MCH BG received by Montana is distributed to counties through MCH contracts. In FY 2010, 54 of the 56 counties were funded and for FY 2011, an additional county indicated a desire to provide MCH services. Those amounts are based on an allocation formula that considers target population and poverty levels. The funding impacts the amount of time and subsequent work which may be "purchased" with the dollars -- some of the smallest counties receive only $1,500 per year. The funding does require that a designated individual be available to monitor MCH needs; the MCH BG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Health Resources Division maintains a Family Health Line. Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line on which Montanans can access information about health care programs for

children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to HMK (the Children's Health Insurance Plan), but training has been provided to staff who answer the line to ensure that they are aware of programs to which families may be referred, including, but not limited to CSHS. See the attachment for the FCHB/MCH script.

2012/Denise Higgins, BS-- Bureau Chief. Ms. Higgins has been the Bureau Chief of the FCHB since December of 2010. She holds BS is in Medical Technology from Illinois State University and is certified by the American Society of Clinical Pathologists. Ms. Higgins was the Newborn Screening & Serology Laboratory Manager for the Montana Public Health Laboratory at DPHHS. She was originally hired by the Montana Department of Public Health & Human Services to develop Montana's birth defects registry and conduct Newborn Screening follow-up. She has also coordinated laboratory bioterrorism activities and served as the Departments Planning Chief for the DPHHS Incident Command Team.

Through vacancy savings and the combining of two sections into one section, Montana maintained allocating approximately 41% of the 2010 and 2011 MHC BG amount to the local health departments based on the allocation formula as previously mentioned. The 2012 Pre-Contract Survey results indicate that Liberty County has opted to decline their 2012 MCH BG allocation, bringing the total to three counties declining MCH BG funds. The remaining 53 counties will receive approximately 41% of the anticipated 2012 funding amount, with the smallest counties continuing to receive the $1500 minimum amount.

The MCHC Supervisor, Bureau Chief, and FCHB Financial specialist analyzed the FCHB FY 2012 salary projections and determined that for FY 2012, 10.1 FCHB/FTEs would be supported with MCH BG funding. The FCHB received additional funding through the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) and from the Grants to States to Support Oral Health Workforce Activities grant opportunities.

The 18 member CSHS Advisory Committee, which includes three parents, has a charter membership and delineates the committee members' roles for their participation. Their two 2012 meetings will include local community CYSHCN service providers presenting information about their function in providing services to the CYSCHCN families.

CSHS parents also participated in several additional opportunities in the past year. The Helena area parent representative attended CSHS staff meetings, regularly met with CSHS staff and provided feedback on projects and pamphlets. An additional parent was sponsored to attend the National Early Hearing Detection and Intervention (EHDI) conference in February of 2011. This parent representative continues to provide program feedback, working with CSHS staff and the newborn hearing program physician champion. Another parent, who is not a CSHS Committee member, is involved with CSHS' cystic fibrosis services and attended the June 2011 CSHS Committee meeting and shared feedback about CSHS cystic fibrosis clinic services.

The CSHS manager will continue to encourage, as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2).//2012//

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a manageable process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow and many clients are served in common. Local input is regularly sought at the state level and is usually in the form

of advisory councils, committees and/or functional work committees.

The Bureau structure facilitates excellent coordination between WIC, Family Planning and MCH Programs. The Bureau organizes and sponsors the Spring Public Health Conference, which provides an excellent opportunity for cross-training between local program staff. Bureau staff also work closely with staff in other bureaus, divisions and sections to address national and state performance measures. Examples of partnerships include coordination of programming to address childhood immunization rates with the immunization program, collaboration with the Health Resources Division on the Family Health Line, and referral of Medicaid and Children's Health Insurance Program (CHIP) families to CYSHCN as needed. Bureau staff participates on advisory groups such as the Montana Council for Developmental Disabilities and includes Family Voices representatives on the Children Special Health Services committee.

The Partnership Diagrams, included as an attachment for the Agency Capacity section, illustrate the Bureau's numerous collaborations with state and private human services agencies across Montana. These partnerships enhance as well as support the Bureau's programs addressing the health care needs of the MCH population, which are reflective of the priority health care needs and performance measures established for 2010.

/2012/The FCHB continued their relationships with their partners as originally stated in 2011. Additional partnerships, illustrated in the Section B: Agency Capacity attachments have been added in the previous year.

Several grant opportunities, such as the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program (ACA MIECHV), Grants to States to Support Oral Health Workforce Activities, and the Montana Best Beginnings State Advisory Council have contributed to the expansion of state, private and community based partners. The ACA MIECHV has resulted in the formation of the ACA MIECHV Agency Work Group, which meets twice a month. This work group is composed of directors of the state's agencies for Title II of the Child Abuse Prevention and Treatment Act (CAPTA); Substance Abuse Services; Child Care and Development Fund (CCDF) Administrator; Head Start State Collaboration Office; State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act; and the Injury Prevention Program. The Grants to States to Support Oral Health Workforce Activities has generated a relationship with the Montana State University/Area Health Education Center (AHEC) to expand educational programs to promote oral health professions by AHEC staff visiting Montana's secondary schools.

Bureau staff members participate on established DPHHS committees and workgroups, such as the WIC Future Study Group and the Injury Prevention Coalition. Staff members have also been invited to participate on new committees, i.e. Western-States Child Death Review Coalition, the DPHHS Director's Office Best Beginnings Strategic Communications Work Group, and the Montana Healthcare Workforce Advisory Committee. Participation on these committees supports the Bureau's educational outreach efforts about the impact that the Title V/MCH Block Grant has on Montana's women, infants, children and families.

The Spring Public Health Conference has been renamed the Family and Community Health Conference. The Children's Health Insurance Program is now the Healthy Montana Kids program//2012//

F. Health Systems Capacity Indicators

Introduction
Montana continues to asses the indicators and data sources for the Health Systems Capacity Indicators (HSCIs) on an annual basis. The Health Systems Capacity Indicators most relevant to the state are used throughout the year to summarize aspects of maternal and child health. The State Systems Development Initiative (SSDI) makes a significant contribution to Montana's ability to report on and interpret data for the HSCIs by facilitating employment of a lead MCH Epidemiologist. The epidemiologist position is responsible for the annual assessment of data sources used for the block grant and exploration of new sources.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	24.9	19.8	18.8	17.6	17.6
Numerator	145	118	115	110	110
Denominator	58191	59581	61292	62438	62438
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data for 2010 are from 2009 to Montana Residents. Data for 2010 will become available mid year in 2011. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2009
Data updated for 2011 submission. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2008
Data updated for 2011 submission. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Narrative:
Medicaid claims data were used as the data source prior to 2005, although the records included only represent a subset of Montana's pediatric population. As of 2005, hospital discharge records are used as the data source for this indicator. Hospital discharge records that are available are currently considered a more complete source of data for this indicator than Medicaid. Although the quality of the limited hospital discharge data that are available continues to improve, a bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass.

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. As a result, the Chronic Disease Bureau of MT DPHHS recently initiated an asthma program and hired a coordinator. A report on the burden of asthma in Montana was released in 2007. A "Montana State Asthma Plan" was released in March 2009,

developed by the Montana Asthma Advisory Group. The advisory group, formed in January 2008, includes over 30 individuals representing 25 agencies and organizations, including the Title V program, and works to coordinate asthma control efforts in the state. The plan describes strategies to improve surveillance systems, partnerships, and services for children with asthma. In particular, the plan calls for legislation to require hospital discharge data reporting.

The most recent National Survey of Children's Health (NSCH), with data from 2007, did not include a question about asthma-related hospitalizations as it did in 2003. It did measure prevalence, with 6.6% of Montana children 0-17 currently having asthma, as compared to 9.0% nationally. In addition, 3.3% of Montana children had asthma in the past but not at the time of the survey, compared to 4.5% of children in the U.S. While the NSCH data show that children in Montana have lower rates of asthma than the rest of the country, the actual prevalence of asthma in the state may be higher than reported. The survey question asked if a healthcare professional had diagnosed the child with asthma, so limited access to healthcare (an identified problem in the state) may influence the prevalence measure.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	91.9	88.0	92.7	88.6	91.2
Numerator	1160	4717	5118	4883	4199
Denominator	1262	5359	5520	5510	4606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data are from the EPSDT CMS-416 Report for FFY2010. For the numerator and denominator, the reporting has been changed to be more specific and is now counted as "total individuals eligible for EPSDT for 90 continuous days."

Notes - 2009
Data are for FFY 2009 from the EPSDT report from the Montana Medicaid Program.

Notes - 2008
This data for FFY 2008 came from the EPSDT report from the Montana Medicaid Program on 4/22/09.

Narrative:
Montana's Medicaid program is in a different division of the MT Department of Public Health and Human Services than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's PASSPORT program to promote the awareness of the medical home concept for CSHCN. Newborn screening also occur for the majority of Montana's newborns, regardless of whether they are Medicaid enrollees or not.

The denominator for 2006 was updated by Medicaid on March 9, 2009 resulting in change in the

Annual Indicator from 22.7 to 91.9 for that year. 2006 data are considered to be an anomaly. In the most recent three years, the indicator shows an average of 90% of Medicaid enrollees receiving at least one screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	0.0	0	0	0	0
Numerator	0				
Denominator	1				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data are not available for this indicator. Montana's CHIP program does not currently collect data that can be used for this Health System Capacity Indicator. The Family and Community Health Bureau continues to collaborate with CHIP on the possibility of reporting on this measure in the future.

Notes - 2009
Data are not available for this indicator.

Notes - 2008
Data are not available for this indicator.

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The Family and Community Health Bureau continues to collaborate with CHIP on the possibility of reporting on this measure in the future. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level. Although this change may not affect Montana's ability to report on this capacity indicator, it is expected to increase the number of children who receive health care and screenings through the CHIP program.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	78.8	78.7	59.7	59.7	59.7
Numerator	9818	9772	7498	7498	7498

Denominator	12462	12414	12567	12567	12567
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
An estimate is provided based on the 2008 data. The indicator will be updated when the analysis is conducted of 2010 data later in 2011.

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
Data for this measure for 2008 should not be compared to prior years due to changes in the way the data are collected. The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. A new birth record format was implemented in 2008, following the 2003 revisions to the US Standard Certificate of Live Birth. The new birth record revised the way data on prenatal care initiation are reported. Also, due to the change the number of records with unknown or missing data increased. In 2008, the percent of births with unknown timing of prenatal care was 6.5%, compared to <1% in previous years. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index.

Narrative:
In 2008, Montana adopted the new birth certificate format (2003 revision of the U.S. Standard Certificate of Live Birth). 2008 data should not be compared with data from previous years due to the changes in the way the data are collected. The substantial decrease in early prenatal care initiation is believed to relate to the new birth record format and the change in the way the data are collected. Other states have experienced the same drop when the new format was implemented.

As the National Center for Health Statistics (NCHS) noted in Births: Final data for 2005, "Prenatal care data based on the revised certificate present a markedly less favorable picture of prenatal care utilization than those based on the unrevised certificate. For the first year the new certificates are implemented, the percentage of women reported to begin care in the first trimester typically falls in a state by at least 10 percent. Much, if not all of this decline is clearly related to changes in reporting and not to changes in prenatal care utilization. In brief, the revised item asks for the exact "date of the first prenatal visit," and the instructions recommend that the information be collected directly from the mother's prenatal care records. The 1989 Certificate, in contrast, includes the less specific "month of pregnancy prenatal care began" (e.g., 1st, 2nd, 3rd), and no source for these data is recommended. " From: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007.

Also, 6% of 2008 records have "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. This is expected to improve in subsequent years as hospitals and staff become more familiar with the new birth certificate format. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index. More complete data in subsequent years will indicate whether the unknowns resulted in an underestimate of the actual number of women with adequate prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	86.1	97.5	93.4	91.0	91.0
Numerator	51200	61532	58450	60207	70888
Denominator	59448	63136	62553	66147	77901
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

The numerator includes children 1 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pulled by child's DOB and are an unduplicated count. Data source for the numerator is MT Medicaid Querypath. The denominator are Montana children 1 through 19 years who are below 133% FPL. Data source for the denominator is US Census data via the CPS Table II. Census data were collected in year 2010 and reflect alternative poverty status in 2009

Notes - 2009

The data source is the Montana Medicaid Program data, via QueryPath.
The data include for any children who were eligible for Medicaid during any part of the fiscal year and were less than 19 years of age. Providers have up to a year to submit claims. All claims for FFY 2009 have not been processed and the actual percentage of recipients with a claim may be higher.

Notes - 2008

The data were updated for the July 2010 submission.
The numerator and denominator were obtained from Medicaid Program.
The data include any child that was eligible for Medicaid during any part of the fiscal year and was 18 or under at the start of the fiscal year.

Narrative:

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the MCHC section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services. Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers.

Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

The same data source was used for 2009 as for previous years. In 2006 there was a slight drop in the Medicaid-paid services, but the numbers increased in 2007. The indicator decreased again in 2008 and 2009, although 2009 data are not yet final, so the indicator may be an underestimate.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	33.4	39.7	52.2	38.6	45.1
Numerator	4099	4897	6406	5112	7356
Denominator	12279	12320	12269	13231	16314
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data are from the EPSDT CMS-416 report MT Medicaid Program for FFY2010. The numerator is eligibles receiving any dental services (6-9); the denominator is total individuals eligible for EPSDT.

Notes - 2009
Data are from the EPSDT report from the Montana Medicaid Program for the FFY 2009.

Notes - 2008
This data are from the FFY 2008 EPSDT report from the Montana Medicaid Program.

Narrative:
Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Education Specialist (within the MCH program) continues to collaborate with Medicaid on dental access issues. Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. Montana continues to experience shortages in dental health professionals overall, and particularly in health professionals who serve Medicaid clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid

and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

The number of EPSDT-eligible children 6-9 years old who received dental services increased substantially in 2008, and then appeared to decrease in 2009. The increase in dental services in 2008 could be related to an increase in Medicaid dental provider rates that went into effect in October of 2007. Dental provider rates were increased from 64% of charges for children to 85% of charges in the aggregate. The reasons for the drop in 2009 are unknown. Montana continues to experience shortages of health professionals overall, and particularly health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid. The guidance for this measure was clarified with HRSA prior to the MCH Block Grant submission in 2009.

Notes - 2009
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2008
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Narrative:
During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is

not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. From 2006 to 2009, no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	8.4	6	7.1

Notes - 2012
"All" includes those with unknown payment source for delivery. Data are for 2009 births.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. The overall rate of low birth weight in 2008 is 7.4%. The low birth weight rate among Medicaid-paid births is 8.6%. Among the non Medicaid-paid births, the rate is 6.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the low birth weight rate drops to 6.3%. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	8	4.1	5.6

Notes - 2012
"All" includes those with unknown payment source for delivery. Data are for 2009 births. These data are considered preliminary. Linked birth-death records that include delivery payment source may be available later in 2011, depending on the availability of vital statistics staff time to link the data sets.

Narrative:
A new birth certificate was implemented in 2008 that collects payment source for births. As of 2008, Montana collects primary source of payment as a part of the live birth record. In 2008, 30% of births were paid by Medicaid. Linked birth-death records using the new birth record format may

be available in late 2010. Linked birth-death-Medicaid files have suggested the rate of infant death among Medicaid paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source for this measure.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	58.5	74.3	65.7

Notes - 2012
"All" includes those with unknown payment source for delivery.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 71.3% of women who gave birth in 2008 began prenatal care in the first trimester.

Among Medicaid-paid births, 65.7% of women started prenatal care in the first trimester. Among the non Medicaid-paid births, the rate is 73.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women who started prenatal care in the first trimester increases to 78.9%. Among births with an unknown payer source, only 42.5% started prenatal care in the first trimester. However, timing of prenatal care initiation was unknown for 40.1% of the births with an unknown payor source. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate	2008	payment source from birth certificate	55.7	61.4	59.7

prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2012
Data are reported for 2008. Updated data for 2009 and 2010 are expected to be available later in 2010.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. Overall, 6.5% of births had unknown adequacy of prenatal care. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 59.7% of women 15-44 years of age who gave birth in 2008 had adequate prenatal care. Among Medicaid-paid births, 55.7% of women had adequate prenatal care. Among the non Medicaid-paid births, 61.4% had adequate prenatal care. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women with adequate prenatal care increases to 66.1%. Among births with an unknown payer source, only 32.7% reported adequate prenatal care and 38.1% had unknown prenatal care adequacy. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2010	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2010	250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's**	**YEAR**	**PERCENT OF POVERTY LEVEL**

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2010	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2010	250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2010	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2012
Montana's SCHIP (CHIP) does not cover pregnant women unless they are under 18 years of age (covered under CHIP as children).

Narrative:
These data come from the CHIP and Medicaid programs. In 2007, the Medicaid eligibility level for pregnant women was increased from 133% to 150% of the federal poverty level. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. However, no provision for increased coverage of pregnant women was included in the bill or legislation. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

According to the latest Title V Information System (TVIS) data (reported by states in 2009), only 11 states had Medicaid eligibility levels for pregnant women lower than Montana's.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	1	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	Yes

Notes - 2012

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics links birth and death record files annually when the datasets are finalized and staff time are available.

Montana's new SPIRIT WIC data system was implemented in late 2009. Linkage of birth certificate data to WIC data is an objective within the next five years.

Montana's newborn screening system has been updated to accommodate the changes in the birth record format for 2008 births and allow for linking of records.

A bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass. However, several years of data are available with some limited use to the MCH program and the data quality continues to improve.

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. Montana's 2011 PRAMS application was approved but unfunded; unfortunately no new PRAMS states were funded in 2011. The 2002 PRAMS data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2012

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey (YRBS). The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2009. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it is a valuable source of information for the five-year maternal and child health needs assessment.

As of 2008, the raw YRBS data are available to the MCH program. 2009 is the most recent year available.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Family and Community Health Bureau (FCHB) has served as Montana's Title V agency for over 20 years. In that capacity, the FCHB has continually monitored, assessed, provided, and advocated, to the extent possible, for the health and well being of the state's women of child bearing age, pregnant women, infants, children and children and youth with special health care needs. The Title V Maternal Child Health Block Grant provides a much needed funding source for addressing the MCH population's unique and oftentimes challenging health needs. In spite of the challenges, an average of 97,007 women, infants, children and children with special health care needs received services supported by the MCH Block Grant.

Montana's 2010 MCH Needs Assessment is a compilation of information, reflecting the work of FCHB programs, and public and private partner organizations. The 2010 MCH Needs Assessment also included input from consumers, which included teens, parents of children with special health care needs, and parents of children and infants ages 0 to 12 years; Montana's Lead Local Public Health Officials; health care professionals; members of the Public Health System Improvement (PHSI) Task Force; and representatives from county health departments that are contracted to provide MCH services in their communities.

There was a consensus from the PHSI Task Force and others working on the SPM selection that Montana must focus on improving Montana's childhood immunization rate; Montana presently has the worst IZ rate for the 19-35 age group in the country. Because of the magnitude of concern, two SPMs were selected to complement the existing NPM 7. SPM #6 focuses on children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis and SPM #7 specifically addresses compliance with the state's requirement of a Varicella immunization for children 19 to 35 months of age. The other five state performance measures address access to care; oral health for children; preconception health; child safety and unintentional injury; and smoking during pregnancy.

Through the years, the FCHB has increased its partnerships and collaborations with other state agencies and private entities for the purposes of providing program activities aimed at any one of the four service levels found in the MCH Pyramid: direct health care, enabling, population-based, and infrastructure building. The new SPMs offer numerous opportunities for developing new partnerships, as well as strengthening the current partnerships, with the goal of maximizing and leveraging when possible, state and federal dollars for the purposes of improving the health of all Montanans, especially the MCH target population.

/2012/

As illustrated in the Agency Capacity attachment, additional partners have been added to the FCHB list of private and public entities addressing any of the services outlined on the Title V pyramid. The Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program grant opportunity has strengthened several established partnerships as well as expanded to new partnerships.

The state's immunization rate continues to be of concern which resulted in the 2012 MCH Block Grant contract being modified. This verbiage, "If NPM 7 or SPM 6 or SPM 7 are selected, the contractor will complete the requirements as outlined on their Immunization Task Order" was included in each contract with the goal of stressing to the health departments the partnership between the FCHB and Communicable Disease Control and Prevention Bureau, which houses the Immunization Program. As stated in the State Priorities section, Montana's immunization rate remains a priority on the Public Health and Safety Division Strategic Plan.
//2012//

B. State Priorities

The Family and Community Health Bureau (FCHB) solicited input on the needs of the MCH population, resources and gaps, and capacity through surveys of local partners and programs providing MCH-related services, focus groups, and key informant interviews. In the fall of 2009, 34 topics were initially identified as possible priority areas for the MCH population. These topic areas included exposure to secondhand smoke in childhood, adolescent tobacco, alcohol and drug use, women's mental health and safe home environment. A more detailed list of the thirty four suggested priority areas is included in the 2010 MCH Needs Assessment document.

Subsequent meetings of the FCHB Needs Assessment Planning Team produced a more reasonable list of priority areas. The initial methodology for selecting the priority areas included:

- Relevant to one of the three MCH populations
- Stakeholder/public input indicates an interest or need
- Data available on the topic
- Data supports need
- Capacity to address topic
- Political will/interests
- Not already measured by a National Performance Measure
- Within the responsibility of the MCH or CYSHCN Director
- System in place to address the need
- Topic or issue can be sufficiently focused
- Possible interventions or approaches to address priority area can be identified

After the FCHB Needs Assessment Planning Team narrowed down the list using the criteria, discussions took place with the Public Health System Improvement (PHSI) Task Force. The PHSI Task Force includes representatives from local health departments (one each from large, medium, small, and frontier-sized counties), and representatives from a variety of agencies or associations throughout the state, including the Montana University System, tribal health departments, local boards of health, the Montana Primary Care Association, and the Billings Area Indian Health Service.

The stated purpose of the PHSI Task Force is to:

- Assess Montana's progress in implementing the goals and objectives of the Strategic Plan for Public Health System Improvement and other system improvement efforts.
- Ensure the implementation of the Strategic Plan with updated "action plans."
- Provide policy development recommendations to state and local agencies regarding public health system improvement issues.
- Advocate for statewide public health system improvement efforts.

Source: (PHSITF Charter retrieved 6/7/2010 at http://www.dphhs.mt.gov/PHSD/phsi/pdf/2009-PHSI-TaskForceCharter.pdf)

The PHSI Task Force was responsible for the final identification of the MCH priority areas and state performance measures based on the availability of data on a measure to indicate a baseline or progress toward a goal, the political and financial support/resources to address the priority area, and most importantly, the capacity for addressing the priority area at a state or local level. Furthermore, the PHSI Task Force recommended that the MCH priority areas and new state performance measures have an identified measure that was relevant at either the state or local level.

The following are Montana's priority areas for its MCH population for 2010 - 2015:

- Child safety/unintentional injury

- Access to care
- Preconception health
- Smoking during pregnancy
- Oral Health
- Montana's rate for the required Varicella immunization
- Montana's rate for the required Diphtheria, Tetanus, and Pertussis immunization series

The FCHB is one of five bureaus in the Public Health and Safety Division (PHSD), which has created its own 2007-2012 Strategic Plan to addresses its mission: To improve the health of Montanans to the highest possible level. The PHSD Strategic Plan (attached document) includes several Health Improvement Priorities that target the MCH population and can be tied to a national performance measure (NPM) or state performance measure (SPM), as illustrated:

PHSD Strategic Plan Health Improvement Priority Area and Related NPM and SPMs

Maintain programs that provide services to women (pre-pregnancy, prenatal, and post-natal) and children.
NPM #1, #2, #3, #4, #5, #6, #8, #9, #11, #12, #13, #14, #17, #18
SPM #1, SPM #2, SPM #3

Reduce unintentional injuries and deaths among Montanans from motor vehicle accidents, falls, poisoning, and other preventable injury-related deaths.
NPM #10, NPM #16
SPM #4

Increase the number of tobacco-free Montanans.
NPM #15
SPM #5

Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis, Varicella and other vaccine
preventable conditions.
NPM #7
SPM #6, SPM #7

The selection of state needs and priority areas is an ongoing process requiring assessment of health
status and system functioning indicators as well as the availability of financial and human resources. The fiscal impact of MCH Block Grant funding remaining at the same level for the past several years has been felt in Montana. As mentioned elsewhere in this application, approximately 42% of the state's MCH Block Grant allocation is distributed to 54 of the state's 56 local health departments. Lack of an increase in the MCH Block Grant does not provide for the ongoing increase in the cost of providing services at the local level. Thus, Montana's total number served continues to decrease.

Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure. As the FCHB moves forward with the new priority areas and state performance measures, the FCHB 2010-2015 MCH Block Grant Strategic Plan is the tool that will be used to monitor, assess, and evaluate that the State Title V Agency and the FCHB continue to have the capacity and resource capability for addressing the national and state performance measures.

/2012/

As stated elsewhere in this document, despite the MCH BG funding being decreased,

vacancy savings and travel restrictions, have contributed to maintaining approximately 41% to 42% of the funding being allocated to the local health departments for addressing the one National or State Performance Measure for their community. Any monetary changes to a local health department's 2012 funding is the result of their county's 2009 population for women of child-bearing age, children ages 0 to 18, and the number of living in poverty.

The Public Health System Improvement (PHSI) Task Force will continue to provide input to the state priorities, which remain unchanged, and to the State Performance Measures.

As stated elsewhere, the state's immunization rate continues to be of concern and as such is a Health Improvement Priority on the Public Health and Safety Division's (PHSD) Strategic Plan which is attached. Immunization also appears to be a priority area for the local health departments. For SY 2012, 35 of the 53 county health departments opting to receive 2012 funding selected an immunization performance measure: 30 selected NPM 7; 4 selected SPM 6, and 1 selected SPM 7. Additionally, the Bureau Chief is invited to participate on the PHSD telephone conference calls with the Lead Local Health Officials, which when appropriate may include discussion about the PHSD's priority areas.

//2012//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7	9	17	15	12
Denominator	7	9	17	15	12
Data Source			MT newborn screening and follow-up program	MT newborn screening and follow-up program	MT newborn screening and follow-up program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	100	100	100	100	100

Notes - 2010
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2009
Fewer cases were confirmed and received timely follow-up compared to the previous year based on the mandatory hospital-based screening of newborns for 28 genetic conditions.

Notes - 2008
2008 was the first year Montana had mandatory hospital-based screening of newborns for 28 genetic conditions. This performance measures includes the results and follow-up for those tests. The increase in the number of conditions is due to the increase in the number and types of tests conducted.

a. Last Year's Accomplishments
The Montana Newborn Metabolic Screening (MT NBS) program is a partnership between Children's Special Health Services (CSHS), the Montana Public Health Laboratory (MT-PHL), and the infant's medical home provider. The overall goal of the Montana Newborn Metabolic Screening Program is that every newborn with an initial abnormal or screen positive result is tracked by the NBS program coordinator to a normal result or appropriate clinical care.

The MT-PHL received all Montana bloodspot specimens and screened for phenylketonuria, galactosemia, congenital hypothyroidism, hemoglobinopathies, and cystic fibrosis. Specimens were then shipped to the Wisconsin State Laboratory of Hygiene (WSLH) for completion of the screening panel. Approximately 4% of babies needed a program-mandated repeat screen due to unsatisfactory specimens or out of range test results on the initial newborn screen. The NBS coordinator was responsible for short term follow-up to ensure that repeat screening occurred, and facilitated secure information sharing of positive screening results with the long term follow-up contractor via CHRIS software. The coordinator manually matched screening records to birth certificates and identified babies who had missed screening within weeks of birth. In several cases, this matching revealed loss of newborn screening specimens during transport to the MT-PHL.

A high percentage of Montana's newborns (98.7%) received at least one bloodspot screen in 2010 that included the American College of Medical Genetics recommended panel. Of the 11954 infants (11915 with a Montana birth certificate) who received at least one Montana newborn screen in 2010, 29 were screen positive for one of the 28 mandated conditions. Of these, 12 were diagnosed with a condition and are being treated. An additional 17 infants were presumed carriers of abnormal hemoglobin traits and referred for follow-up genetic services. Infants with diagnosed conditions in 2010 included two with congenital hypothyroidism, one with sickle cell anemia, two with a disorder of fatty acid metabolism, one with organic acidemia, and six with cystic fibrosis.

In June 2009, the NBS coordinator position was re-defined under the supervision of the MT-PHL. The coordinator relayed abnormal results directly to providers to give them more complete, consistent, and clinically relevant information. The coordinator prepared an "Unsatisfactory Specimen" policy in December 2009 for the MT-PHL. Standards consistent with Wisconsin's are now applied to Montana specimens. In December 2009, the MT-PHL called more than 7% of NBS specimens unsatisfactory. The coordinator provided submitters with intensive education and reinforcement by phone and email. Unsatisfactory specimens dropped to 1.3% by April 2010 and continued at this level.

As of June 2010, the follow-up contractor employed a board-certified biochemical geneticist who

resides in Montana. MT NBS partners (CSHS, laboratory, follow-up contractor) met every other month and reviewed program statistics (% infants screened, initial positives, screen positives, confirmed diagnosis, treatment), accomplishments, and challenges for calendar year 2010 in order to improve sustainability and accountability for the program. This group reached consensus on a change in reporting protocol for unknown hemoglobin variant traits which was then adopted by the MT-PHL. A fact sheet on unknown hemoglobin variants was developed and is now faxed to providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify babies with Montana birth certificates who have no newborn screening data within eight weeks of their birth and determine reason for no screening.		X		
2. Ensure that all newborns with confirmed conditions are referred to the contractor for long-term follow-up and relay results to the primary care provider in the medical home.		X		
3. Ensure partners and decision makers review program statistics, accomplishments, and challenges to improve sustainability and accountability for the program.				X
4. Apply a consistent standard for unsatisfactory specimens with Wisconsin and educate submitters to reduce the unsatisfactory percentage.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Screening for Severe Combined Immunodeficiency (SCID) was added to the recommended newborn screening (NBS) panel in 2010. MT NBS Program personnel viewed a national webinar on SCID results from Wisconsin, California, Massachusetts, and New York in May 2011.

Montana will monitor standardization of algorithms for screening, confirmatory testing and referral for transplant. As of June 2010, the follow-up contractor employs a board-certified biochemical geneticist who resides in Montana, staffs the regional metabolic clinics, and provides expert consultation to primary providers.

In December 2010, MT PHL implemented a more comprehensive referral protocol for reporting out of range results. The NBS coordinator tracks most infants with abnormal results to a normal repeat screen. Those infants with presumptive positive results are referred immediately to the contractor for documentation in CHRIS of confirmatory testing, definitive diagnosis, and clinical management.

In January 2011, program partners and cystic fibrosis (CF) specialists reviewed program data and updated the age-dependent ranges for Montana's IRT/ IRT screening algorithm (implemented March 2011). Additions to the website this year include information about CF screening, unknown hemoglobin variants, and privacy policies.
As of November 2010, NBS reports include birth weight and other demographic information, distinctly flag out-of-range results, and have clear recommendations for the provider.

c. Plan for the Coming Year

As SCID screening is standardized and adopted by more state programs, the MT NBS program will consult with experts, providers, and other interested parties regarding addition of SCID to Montana's mandated panel. The screening test would be performed at a regional center, presumably Wisconsin. The health department will need to determine what resources for screening, treatment, and counseling are available. Additions to the mandated panel are made by health department regulations, Administrative Rules. Legislation is not required for additions to Montana's bloodspot screening panel.

MT NBS partners and CF specialists will review data after the updated IRT/ IRT screening algorithm has been in place for approximately twelve months. CF specialist cooperation with the CSHS-supported regional clinics should facilitate documentation of confirmatory testing, definitive diagnosis, and clinical management.

MT NBS partners and Montana's providers of neonatal intensive care will work together to streamline screening for premature and sick infants, based on finalized national guidelines from the Clinical and Laboratory Standards Institute. More than 40% of Montana infants with initial out-of-range screening results are receiving intensive care. The goal is to complete NBS for every sick/ premature infant in the shortest period of time, with the highest degree of reliability and using the fewest number of specimens. Neonatal providers have requested clearer Administrative Rules from the health department after a consensus is reached on the optimal protocol.

A new laboratory supervisor for newborn screening began at MT-PHL in March 2011. The NBS coordinator works with her to improve program quality. The NBS coordinator will complete deferred projects such as submission of additional anonymized specimens to a regional CDC-funded project evaluating 2nd tier testing for congenital adrenal hyperplasia and other conditions. The NBS coordinator will also take part in a deferred quality improvement project to evaluate specimen transport processes and track specimen transport times to ensure timely delivery of specimens to MT PHL. A LEAN analysis of data handling in the program was initiated in 2010. When the analysis is complete, the health department will determine whether available resources will support addition of customized software for tracking and documenting screening completion, linking birth and screening records, and managing and reporting interoperable NBS data. Expansion of the NBS program website will continue as part of a department-wide upgrade to include additional information for providers and families.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**12070**					
Reporting Year:	**2010**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	11915	98.7	0	0	0	
Congenital Hypothyroidism	11915	98.7	2	2	2	100.0

(Classical)						
Galactosemia (Classical)	11915	98.7	0	0	0	
Sickle Cell Disease	11915	98.7	1	1	1	100.0
Biotinidase Deficiency	11915	98.7	2	0	0	
Congenital Adrenal Hyperplasia	11915	98.7	4	0	0	
Cystic Fibrosis	11915	98.7	7	6	6	100.0
Maple Syrup Urine Disease	11915	98.7	1	0	0	
Tyrosinemia Type I	11915	98.7	2	0	0	
Hemoglobinopathy	11915	98.7	18	1	1	100.0
Acylcarnitine profile for (5) fatty acid oxidation disorders (CUD,MCAD,LCHAD,VLCAD,TFP)	11915	98.7	8	2	2	100.0
Acylcarnitine profile for (9) organic aciduria disorders (HMG,3MCC,BKT,GA1,IVA,CblAB,MUT,MCD,PROP)	11915	98.7	2	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	55.3	55.6	56.5	56.5	56.5
Annual Indicator	54.0	56.5	56.5	56.5	56.5
Numerator	188				
Denominator	348				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	56.5	56.5	56.5	56.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of families that had children with special health care needs ages zero to 18 years in MT

who partnered in decision making at all levels and were satisfied with the services they received was 56.5 percent in 2005/2006. This is lower than the national percentage of 57.4 in 2005/2006.

Shodair, the contractor for the genetics and newborn screening follow-up contractor, conducted patient satisfaction surveys. See attachment. In 2010the survey instrument was sent to 734 families and 110 families returned the survey. The overall family satisfaction score from 2010 clinics was 4.9 (scale of 1-5 with 5 being the highest).

Shodair conducted its 2nd annual Metabolic Day in August of 2010. The event hosted families, provided information about living with metabolic conditions, and offered support and networking opportunities. Families were given a survey on metabolic and genetics clinics which asked for input on a variety of topics, including the extent to which the family's feelings were valued and respected, interaction with the child and whether families received the information they needed.

Shodair created binders for the metabolic patients attending Children's Special Health Services (CSHS) interdisciplinary metabolic clinics. These binders had gender specific materials and space for all clinic related materials so the patient and family could retain and organize the information.
CSHS assessed the need for the families of children and youth with special health care needs (CYSHCN) to purchase additional health care coverage. CSHS data shows 99% had health care coverage in FFY 2010 (44 had private insurance, 16 had Medicaid and 1 was self-pay). Also, because of the recent Medicaid and Children's Health Insurance Program expansions, families have been able to benefit from coverage from Department of Public Health public assistance programs.

CSHS successfully added additional staffing requirements in the 3 regional pediatric specialty clinic sites. The nurse to visit ratios continued to be high at 1:635.

CSHS attended the Family Day at the School for the Deaf and the Blind and presented information on the CSHS program and partners, as well as networked with families about needs and ability to access care in MT. CSHS received several ideas and suggestions for activities that would benefit CYSHCN. These ideas ranged from parent resource libraries to creating on-going means to solicit feedback about accessing services in MT. CSHS did not implement any of these suggestions due to lack of staff and resources to assess the need and ability to implement.

CSHS and the CSHS Advisory Committee welcomed a new parent representative, who attended her first Advisory Committee meeting in June of 2010. She also attended monthly CSHS staff meetings, provided input on the section activity plan, and met periodically with the CSHS manager. Two other parent representatives continued to serve on the Advisory Committee.

Two of the regional staff, who served on the Advisory Committee, have children with special health care needs. Each member continually shared valuable feedback with CSHS to ensure the program and its services incorporated feedback from CYSHCN and their families. The CSHS Medical Advisor continued to provide technical assistance and guidance to the group as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued active parent participation in CSHS Advisory Subcommittee and other section activities.				X
2. Ongoing collection and analysis of the client satisfaction survey from the Regional Pediatric Specialty clinics.				X
3. Parent participation and input on the CSHS activity plan.				X
4. CSHS Medical Director to continued to provide technical assistance and guidance.				X

5. CSHS assessed the need for the families of CYSHCN to purchase additional health care coverage		X		
6. Added additional staffing requirements in the 3 regional pediatric specialty clinic sites				X
7.				
8.				
9.				
10.				

b. Current Activities

CSHS continues to assess client satisfaction at interdisciplinary clinics and programmatic changes are frequently based on this feedback. Coordinators at the Great Falls Clinic conducted a patient survey in the fall of 2010 to collect information on such things as travel distance. (See attachment) CSHS is working with a parent representative to develop a survey about CSHS Cystic Fibrosis (CF) clinics to evaluate family feedback on the availability and level of services offered at clinics. There will also be a follow-up assessment on the Newborn Screening Follow-up Program and Metabolic Clinic. Shodair, the contractor for the genetics program in MT, will survey each family about clinic interaction.

CSHS was able to coordinate funding to send a parent representative to the 2011 Early Hearing Detection and Intervention (EHDI) conference. She was invited to attend an Advisory Committee meeting to share feedback.

The Rural Institute, Montana's Center of Excellence in Disabilities, conducted surveys after 2 webinar trainings ("Social Security Work Incentives" and "Dating and Healthy Relationships") funded in part by CSHS Of survey participants, 92% rated the webinars they were satisfied or very satisfied, and 80% reported the content of the webinars would be helpful in their lives. (See attachment)

CSHS is offering a stipend to a parent to review the MCH Block Grant Application and offer feedback on any areas that are of interest to families of CYSHCN.
An attachment is included in this section. IVC_NPM02_Current Activities

c. Plan for the Coming Year

CSHS will continue to invite parent representatives to the bi-annual CSHS Advisory Committee meetings to provide input on Committee decisions. A parent representative will also take part in periodic CSHS staff meetings and offer a parent's perspective on program activities and materials developed for distribution by the program.

CSHS plans to provide funding for a parent representative, whose child has been diagnosed with hearing loss, to attend the 2012 National Early Hearing Detection and Intervention Conference as part of the state EHDI Team. The team will also include, the Universal Newborn Hearing Screening and Intervention (UNHSI) Coordinator, an outreach consulting audiologist from the Montana School for the Deaf and the Blind, a pediatrician designated as the Hearing Champion from the Montana chapter of the American Association of Pediatrics, and a hospital employee from one of the birthing facilities, which provides newborn hearing screening services in Montana . CSHS will ask the parent representative to share feedback about the conference and UNHSI program activities to program staff and stakeholders in an effort to ensure that the UNHSI program is meeting the needs of Montana families.

CSHS plans to restructure the Universal Newborn Hearing Screening and Intervention Stakeholders' group, which will include one or more parent representatives. This group will provide input on program activities and help guide future activities and programmatic decisions.

CSHS will continue to require CSHS contractors to conduct client satisfaction surveys and

monitor survey results. Results will be analyzed by CSHS in an effort to identify areas of contracted services in need of improvement to better meet the needs of CYSHCN families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	52.6	52.6	50	50	50
Annual Indicator	51.7	45.9	45.9	45.9	45.9
Numerator	361				
Denominator	698				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	50	50	50	50	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percentage of CYSHCN in MT who received coordinated, ongoing, comprehensive care within a Medical Home was 45.9 percent, which is slightly lower than the national percentage of 47.1 percent.

In FFY 2010, 61% of CSHS program clients reported having an active primary care provider (PCP). Providing referrals for PCP and collecting this information is a standard Children's Special Health Services (CSHS) interdisciplinary clinic activity. Providers of records received copies of specialty clinic visits to facilitate continuity of care.

CSHS continued to maintain its website with listings of pediatric specialty clinics and contact information for scheduling. During the annual Montana American Academy of Pediatrics (MT AAP) meeting, a discussion with PCPs was led by the CSHS Medical Advisor regarding specialty provider shortages in MT. The Medical Advisor also provided regional updates and led a

discussion of CSHS' role in contracting and supporting specialty providers.

CSHS participated in the National Academy for State Health Policy (NASHP) technical assistance grant project for medical homes. There were two stakeholder meetings where participation included the Children's Mental Health Bureau, hospital administrators, health care providers, health insurance company medical directors, county health representatives and two MT Legislators. The stakeholder group has received expert advice regarding establishing a multi-payer medical home concept for the entire state, how to fund such an effort, and technical assistance on how to facilitate these discussions.

CSHS continued to participate in the MT AAP to address topics such as reimbursement rates, medical homes, and care coordination and transportation issues.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed.			X	
2. CSHS continues to maintain its website with listings of pediatric specialty clinics and contact information for scheduling.				X
3. CSHS continued to strengthen relationships between the pediatric specialty clinics and primary care providers.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS is completing year 3 of the Child Health Referral & Information System (CHRIS) web application development. Much of the work completed during this development phase is case management functionality to assist with coordination of care for children and youth with special health care needs (CYSHCN). Functionality now in development will allow a child's primary care provider to view clinic schedules with specialty provider information and to make electronic client referrals for clinic evaluations.

CSHS has developed a Cystic Fibrosis Care Plan which can be accessed by regional nurse coordinators. The care plan is reviewed with the child and family prior to leaving cystic fibrosis (CF) clinic and a copy of the plan is faxed to the child's primary care provider following clinic.

CSHS has continued participation in the MT medical home project. The group has weekly conference calls which often invite guest speakers to share expertise about payment reform and project implementation.

CSHS continues to participate in Medical Home Stakeholder meetings. In the coming year, the stakeholder group will adopt criteria to certify practices as Medical Homes. Also, CSHS will continue to be involved in planning a medical home initiative to include a certification process for practices that choose to participate.

CSHS is contracting with a nurse to assess the different CYSHCN referral sources and develop a referral program that will coordinate referrals to county health departments.
An attachment is included in this section. IVC_NPM03_Current Activities

c. Plan for the Coming Year
CSHS will continue development of the CHRIS web application as funding allows. Funding for development is from several sources. The primary development for the coming year will focus on CSHS clinic scheduling /management functionality and expanded tracking, reporting, and referral management for the Universal Newborn Heading Screening Intervention (UNHSI) Program Also, the functionality allowing primary care providers to access clinic schedules is still considered a priority development effort and is scheduled for completion during the coming year.

To facilitate coordination of care for clients attending cystic fibrosis clinic, CSHS will migrate care plan functionality to the web application. This will make care plans more accessible to regional pediatric specialty clinic staff and will allow CSHS to more easily collect data that is important for monitoring client outcomes over time. Other care plans will be developed as funding allows.

CSHS will continue to participate in Medical Home Stakeholder meetings. In the coming year, the stakeholder group will continue to work towards certifying practices as Medical Homes and possibly develop a self-assessment tool. The stakeholder group will continue gathering data about primary care providers in MT and assess medical home pilot projects that have occurred in MT. The group plans to assess and vote on the level of National Committee for Quality Assurance (NCQA) standards to be applied in MT.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	50.4	50.5	55.2	55.2	55.2
Annual Indicator	48.8	55.2	55.2	55.2	55.2
Numerator	350				
Denominator	717				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	55.2	57	58.5	58.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
CSHS continued to encourage and support sustainability of follow-up services for children and youth with Special Health Care Needs (CYSHCN) by acting as a resource for clients, primary care and other providers, parents, local health departments, and payer sources.

By raising awareness and understanding of the needs of this population and their families, CSHS builds critical links for ongoing care. CSHS continued billing for Cleft/craniofacial, Cystic Fibrosis, and Metabolic Clinics. This funding is used to support the regional pediatric specialty clinic (RPSC) sites. Newborn Screening (NBS) follow-up program continues to be supported by special revenue. Effective December of 2009, CSHS began sponsoring cystic fibrosis (CF) inter-disciplinary clinics and the revenue achieved is used to sustain CSHS inter-disciplinary clinics. Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMKP) continue to support the CSHS clinics.
During FFY 2010, CSHS billed a total of $532,400.00 for CSHS sponsored team clinics and was reimbursed $359,040.91 for 67% of billed charges. Cleft clinic charges were reimbursed at 74%; Metabolic clinic charges were reimbursed at 58%; and Cystic Fibrosis charges were reimbursed at 63%.

For FFY 2010, 61 clients were eligible for up to $2,000 of financial assistance from CSHS. Of the 61, 1 did not have health care coverage; 16 had HMK; 11 had HMKP; and the remaining clients enrolled had some type of health coverage. CSHS enrollment continues to decline due to the changes made in HMK & HMKP. Both programs have raised their poverty guidelines for eligibility.

Effective February 2010, CSHS began receiving SSDI summaries of findings. The physician-drafted forms assess the status of a child's disability.

In December 2009 a 2% rate increase was implemented for targeted case management (TCM) programs for high risk pregnant women & CYSHCN.

CSHS worked with HMK to establish electronic referrals where applicants indicated their child has special health care needs. These applicants are reviewed and receive information about RPSC and CSHS financial assistance.

CSHS continued to work with health care coverage agencies to promote coverage for services needed for CYSHCN. This activity included negotiating rates for CSHS clinics, assisting families with claim appeals, and communicating with health care coverage agencies regarding the necessity of coverage for services and supplies.

CSHS continued to communicate the gaps if coverage to all health care coverage agencies, including when they are a third party payer.

CSHS continues to work with Indian Health Services prior to conducting reservation specialty clinics to ensure that families have a health payer source.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue providing for limited financial assistance for medical services.	X			
2. Continued partnership with Medicaid program regarding		X		

pediatric specialty services in Montana.				
3. Ongoing shared referrals with Health MT Kids (HMK is CHIP).		X		
4. Communication with providers to accept negotiated rate.		X		
5. Provide information to HMK and other insurance regarding coverage needs of CSHCN.				X
6. Continue providing information to health care providers regarding the HMK expansion.		X		
7.				
8.				
9.				
10.				

b. Current Activities

CSHS continues to monitor the health coverage status of all CYSCHN referred to or receiving services from CSHS. Individual health coverage is tracked in the CSHS database, Child Health Referral and Information System (CHRIS). CHRIS is a shared application used by multiple CYSCHN service providers, not all of whom collect health coverage information on clients. Better reporting of health coverage data is a quality assurance issue now being addressed for CSHS.

Two Regional Pediatric Specialty Clinic sites are now staffed by half-time social workers who work with families to obtain health coverage and other assistance. This follow-up has been a long term goal for CSHS and has already had a positive impact for families.

CSHS continues to support the program expansions of Medicaid (HMKP) and CHIP (HMK). A CSHS staff member will attend an extensive Medicaid eligibility training session in July.

For FFY 2011 to date, 54 CSHS clients have been eligible for up to $2,000 in financial assistance using block grant funding. Of the 54 clients, 1 did not have health care coverage. To date, CSHS has $26,251.16, with a cost per child averaging $486.13. All applicants who apply for financial assistance are assessed for HMK or HMKP eligibility. There have been a growing number of requests for Medicaid clients needing genetic testing from out-of-state labs. CSHS is assessing the option of using program funds to cover these services.

c. Plan for the Coming Year

CSHS plans to pursue team billing of insurance companies that are currently not reimbursing CSHS for Cystic Fibrosis clinics.

CSHS plans to implement quality assurance measures to improve the collection of health coverage information in the Child Health Referral and Information (CHRIS) data system. CSHS CHRIS program data represents a snapshot of the CYSCHN population in Montana, and is very useful for understanding the coverage issues that CYSCHN may be experiencing. For example, CSHS is currently reviewing payment information for cochlear implants and health coverage information is under-reported for this population.

Adding a half-time social worker to the 3rd regional pediatric specialty clinic site is under discussion. Helping families to access health coverage can be a time consuming process. Knowledgeable, on-site assistance as well as follow-up between clinic visits will help families navigate the health care system.

CSHS will continue to work with partners, specifically Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMKP) to address services not covered by these entities. HMK does not cover durable medical equipment like nebulizers for children with asthma, oxygen necessities, or CPAP's for children with sleep apnea. To cover these items generally means fewer emergency room visits. CSHS staff will receive training about HMKP eligibility to further enable CSHS staff to

accumulate knowledge of the many programs under the HMKP umbrella and be able to guide families as needed.

CSHS will continue offering financial assistance for non-covered or non-accessible services for CYSHCN with public and private health care coverage as well as offer assistance to achieve health care coverage for CYSHCN without adequate coverage. CSHS will continue advocating for non-covered durable medical equipment coverage through the HMK Program as well as for coverage for out of state genetic testing for the Medicaid population.
CSHS will continue referring families to patient assistance programs as needed.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	72.6	72.8	88.6	88.6	88.6
Annual Indicator	71.6	88.6	88.6	88.6	88.6
Numerator	250				
Denominator	349				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	88.6	90	90	90	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), 88.6 percent of MT respondents thought that community-based service systems were "usually" or "always" organized so they could easily use them, compared to 89.1 percent nationally.

CSHS continues to promote increased access to specialty care for CYSHCN at the Regional

Pediatric Specialty Clinics (RPSC) through contracted services and consultation. The RPSC demonstrated continued growth during FFY 2010 with 3803 clinic visits. This represents a 17% increase in clinic visits from FFY 2009. Staffing is adequate at the sites, but with continued growth, the clinic follow-up can be challenging for current staff levels.

Pediatric Specialty clinic development efforts continued to focus on clinical care for clients with cystic fibrosis during FFY 2010. Standardized documents for nutrition, social worker, and respiratory therapy were developed for and implemented for use at cystic fibrosis (CF) clinics. A care plan to be used for reporting and documentation has been developed and is being is used by regional CF team clinic staff. CF clinic clients/parents leave the clinic with a copy of their care plan which is faxed to their primary care provider (PCP) on the day of clinic. Care plans have decreased nurse coordinator documentation time considerably.

A certified nurse specialist (CNS), arranged for a CF education day in Billings during August 2010.

New pediatric specialty providers in MT last year were a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist.

CSHS worked with Healthy MT Kids Plus (HMKP/Medicaid) to provide information about the availability of pediatric services in Montana.

Health Montana Kids Plus (HMKP), Healthy Montana Kids (HMK), and CSHS continued to coordinate services between out of state facilities and Montana providers. CSHS contracted with a nurse who is working with Blue Cross Blue Shield of MT, the Medicaid Health Improvement Program (HIP) and Seattle Children's Hospital, focusing on the children and youth with special health care needs (CYSHCN) that are receiving services outside MT, discharge planning, and linking patients to local health departments.

Shodair provided clinical genetics services in 80 outreach clinics so the 76% of families that reside outside the Helena area could receive some services locally. Individuals with metabolic conditions identified by newborn screening are seen in regional clinics which are staffed by Shodair in cooperation with local resources. Shodair also works with county health departments across Montana to coordinate services for clients in their communities.

CSHS continued contacting payers which are not reimbursing for clinic visits, with the intent to increase payments.

CSHS also continues to support CF inter-disciplinary clinics.

CSHS participated on the board for the Pediatric Epilepsy Tele-health (PET) grant which will provide pediatric follow-up neurological care for children with epilepsy.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS continues to promote increased access to specialty care for CYSHCN at the Regional Pediatric Specialty Clinics (RPSC) through contracted services and consultation.				X
2. RSPC clinic development efforts continued to focus on clinical care for clients with CF. Standardized documents for nutrition, social worker, and respiratory therapy were developed and implemented. Care plans were used for reporting and documentatio				X
3. CSHS plans to continue contacting payers that are not				X

reimbursing clinic visits, with the intent to increase payments.				
4. Rosalie Bush, certified nurse specialist (CNS), arranged for a CF education day in Billings during August 2010.			X	
5. CSHS worked with health care coverage agencies to link families to community resources		X		
6. New pediatric specialty providers in MT last year were a pediatric neurologist, a hospitalist/pediatric pulmonologist, and a metabolic geneticist. All are rendering services to CYSHCN.		X		
7.				
8.				
9.				
10.				

b. Current Activities

Because of the distances families travel for care, access to specialty providers continues to be a focal point of Montana's CYSCHN program, CSHS. The downturn in the economy and the cost of gas adds to the complexity of accessing care in a rural state.

CSHS has a part-time nurse consultant whose responsibilities include coordinating follow-up community services for newborns and children who are admitted to out of state hospitals.

The North Central Region Pediatric Specialty Clinic administration is under re-organization. Expansion of clinic services is on hold until this process is completed. The Western Region Pediatric Specialty clinic has a strong affiliation with Seattle Children's hospital and has added Pediatric Gastrointestinal clinics this year. In addition, Seattle Children's Hospital is providing pediatric surgery back-up for the Community Medical Center in Missoula. The Eastern Region Pediatric Specialty Clinic has stable staff and continues to expand with the addition of pediatric neurology clinics.

CSHS continues to coordinate care and referrals with other programs including CHIP (HMK), Medicaid, and the MT School for the Deaf and the Blind, and the social security Disability Determination Bureau. CSHS continues to partner with county public health offices, health care coverage agencies and other partners to ensure access to community resources where available.

All 3 regional sites and Shodair conduct outreach clinics to promote better health outcomes.

c. Plan for the Coming Year

CSHS plans to contract with and provide consultation to the Regional Pediatric Specialty Clinics (RPSC). The RPSC are crucial partners in the pediatric health care system in Montana. CSHS will seek to stabilize funding for nutrition and social work services at the RPSC with additional funding for the regional sites. In addition to staffing the three CSHS sponsored clinics (Cleft/craniofacial, Cystic Fibrosis, and Metabolic Clinics), the county health departments will continue to be available for follow-up and other RPSC clients.

CSHS will continue to facilitate the transition of adults with cystic fibrosis to adult clinic services.

CSHS plans to continue building the follow-up system for CYSHCN who receive care out of state, have extended stays in Newborn Intensive Care Units, and have high special needs by expanding its linkages with public health home visiting, Part C, Medicaid (including the Medicaid Health Improvement Program), CHIP, private payers, out-of-state hospitals and primary care providers.

CSHS will utilize the FFY 2011 genetic services needs assessment to assess and draft a state genetics plan. The needs assessment and state plan will be a result of interviews with genetics

patients/families and medical providers in Montana. The state genetics plan will have several focus points, including the need to continue outreach services in order to promote access and address transportation issues for families of CYSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	6	6.5	46.5	46.5	46.5
Annual Indicator	5.4	46.2	46.2	46.2	46.2
Numerator	8				
Denominator	147				
Data Source			CSHCN Survey	CSHCN Survey	CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	46.5	47.5	47.5	47.5	

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments
According to the 2005-2006 National Survey of Children with Special Health Care Needs (NS-CSHCN), the percent of Montana youth with special health care needs who received the services necessary to make transitions to adult health care, work, and independence was 46.5, which is higher than the national percentage of 41.2.
Shodair Children's Hospital, a contractor for Montana's genetics program and metabolic specialty clinics, provided transition information to youth ages 14-18. These informational resources addressed education, employment, medical care, and living arrangements.

A CSHS staff member continued to serve on the Montana Transition Information and Resource Center (MT-TIRC) Advisory Board. The Board continued to address issues identified in part by

youth members who make up more than 50% of the membership. Among these issues were healthcare, mental health issues, work, and living arrangements. The Board identified several new ways to provide mentoring to families in the transition process through social media such as Facebook and MySpace.

The MT TRIC Board, including the CSHS member, attended the 2009 Montana Youth Transitions Conference, where they had a booth to provide transition resources and information. Topics presented at the conference included the Social Security System, the Vocational Rehabilitation Program, assistive technologies, and transition assessments for Individualized Educational Plans as youth begin the transition process in school. Approximately 250 attended this conference.

The CSHS supervisor met with the Administrator of the Disability Services Division in April of 2010 to learn how CSHS could become more of a presence and voice for transition services in Montana. This opportunity provided for guidance regarding additional partners and outreach opportunities through schools and disability programs in MT.

CSHS continued to provide limited support to youth receiving financial assistance for services and at regional clinics regarding transitions.

CSHS continued to work with existing partners to identify transitions resources. Options for collaboration with other partners were explored to increase CSHS services to youth in transition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions.		X		
2. Explored options to collaborate with several new organizations who serve youth in transition and their families.				X
3. A CSHS staff member is a member of the MT-TIRC Advisory Board and attends the quarterly meetings.				X
4. Continued work with existing partners to identify transition resource opportunities and funding opportunities.				X
5. CSHS continued to explore local, state and national transition resources.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS is actively working to identify new partners to increase its collaborative efforts to address transition issues faced by CYSHCN. New funding sources have been identified and transition activities have been discussed with partners in preparation for the 2012 State Implementation Grant.

Staff from Shodair and the regional pediatric specialty clinics (RPSC) continues to work with youth ages 14-18 on transition issues by providing education, referral to services, and information on resources available in Montana.

Information on transition from health care programs such as Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMK Plus) is sent to families when applications for financial assistance are sent.

A CSHS staff member continues to serve on the MT-TIRC Advisory Board. The board remains intact in part due to CSHS funding designated to 6 webinars focusing on transition issues such as Social Security and youth transitioning into handling their own medical affairs in adulthood.

Communication with health care payers continues to address complications that occur when youth transition to adult care/services.

CSHS has been working with the Department's staff to discuss website enhancements. CSHS is considering compiling a list of transition resources on a dedicated webpage, which will provide informational website links and other transition resource information.

The Montana Cystic Fibrosis (CF) teams have identified transition to adult care as a focus of effort.

c. Plan for the Coming Year

CSHS staff will continue to send transition information with CSHS financial assistance applications and provide information to families regarding transitioning from health care programs such as HMK and HMKP to other payment sources.

CSHS will continue to collaborate with partners and CYSHCN to promote transition services. CSHS partners such as Parents Lets Unite for Kids (PLUK, the MT Family Voices agency), the Rural Institute (Montana's Center of Excellence in Disabilities), and Summit Independent Living Center (advocacy and resource center for Montanans' with disabilities), will continue to build and promote transition programs and services.

Financial support will be offered to support continuing projects such as webinars that address transition issues, website maintenance for a transition website for youth, and an advocacy program in schools.

Other opportunities for collaboration will be explored. CSHS will continue efforts to identify organizations in other regions of the state which serve youth in transition and opportunities for expanded support of transition activities in Montana.

A new webpage will be added to the CSHS website to provide links to other sites that provide transition information and resources.

Additional funding sources will be sought to increase the capacity of CSHS to address transition and other program priorities.

CSHS will continue communicating with other CYSHCN state programs and Association of Maternal & Child Health Programs (AMCHP) about challenges and opportunities in order to help identify new opportunities to provide transition services and information to Montana youth and their families.

Shodair will continue to work with youth aged 14-18 on issues related to transition to adulthood at genetic and metabolic clinics.

Communications with healthcare payers will continue to help address issues that arise when youth transition into adult services.

A CSHS staff member will continue to serve on the MT-TIRC advisory board and will attend the annual Montana Transitions conference.

Regional CF clinic coordinators will finish a transition checklist for children and families. This

checklist will follow cystic fibrosis clients throughout the development cycle. The checklist is now in draft form and will be implemented during fall 2011 clinics.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	80	80	80	80	70
Annual Indicator	73.6	75	65.5	60.3	60.3
Numerator	12231				
Denominator	16618				
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	65	65	65	65	67

Notes - 2010
The source of data is the National Immunization Survey (NIS), Q3/2009-Q2/2010. Please note the 95% confidence interval is +/-7.3. The data for 2010 are not final.

Notes - 2009
The source of data is the National Immunization Survey (NIS), July 2008-June 2009 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0809.htm). The data for 2009 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 7.0.

Notes - 2008
The source of data is the National Immunization Survey (NIS), July 2007-June 2008 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0708.htm). The data for 2008 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 6.7.

a. Last Year's Accomplishments
The Montana Department of Public Health and Human Services (DPHHS) Immunization Program continued to encourage and support vaccination activities throughout the state, including:
1. Improved varicella surveillance: including using WIZRD data to review histories of chickenpox infection and concentrating efforts during outbreaks on adolescents and younger children without

2 doses of the varicella vaccine
2. Increasing Tdap/Td booster rates for children in grade 7 by encouraging active participation of school nurses and administrators, and public health nurses.
3. Increasing the DTaP immunization rate among 2-year olds.
4. Providing educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents.
5. Conducting Regional Immunization Workshops for Local Health Jurisdictions to provide updates and training.
6. Encourage testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of positive test results to state or local health departments for case management and follow up.

The Family and Community Health Bureau (FCHB) which houses the Maternal and Child Health (MCH) Coordination Section provided technical assistance and programmatic support to local health departments which selected National Performance Measure (NPM) 07. Twenty-nine counties selected NPM 07 as their focus and conducted activities to help improve immunization rates in their counties.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase Varicella surveillance				X
2. Increasing Tdap/Td booster rates for children in grade 7			X	
3. Increasing the DTaP immunization rate among 2-year olds			X	
4. Provided educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents		X		
5. Conducted Regional Immunization Workshops for Local Health Jurisdictions				X
6. Encouraged testing of all pregnant women for Hepatitis B infection			X	
7. Provider use of WIZRD continued to increase				X
8. The electronic import of immunization records from the Indian Health Service were conducted weekly by one Tribal Health Department				X
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide for local health departments to provide them with best practices to improve immunization rates in their counties. (See attached)

The Public Health Home Visiting (PHHV) program will assess whether infants in the program receive their two, four and six month immunizations and the PHHV provider will counsel parents on the importance of continuing scheduled immunizations for infants.

The Children and Youth with Special Health Care Needs (CYSHCN) Section will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.
The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS Immunization Section will partner with 57 contractors to improve the immunization

rate in Montana. The Immunization Section has monthly phone calls with all partners to provide technical assistance and programmatic support.
An attachment is included in this section. IVC_NPM07_Current Activities

c. Plan for the Coming Year
The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

See the attached map indicating the county health departments that will be addressing NPM 7 in FY 2012.

An attachment is included in this section. IVC_NPM07_Plan for the Coming Year

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.6	17	16	16	17
Annual Indicator	17.6	16.8	18.6	18.9	18.9
Numerator	359	343	367	359	359
Denominator	20424	20388	19782	19015	19015
Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	17	17	16	16	16

Notes - 2010
Data reported are for 2009. 2010 data are not yet final. They are expected to be available later in 2010.

Notes - 2009
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2009. The denominator is the latest mid-year population estimate (May 2010 release) for females ages 15-17 in Montana in 2009.

Notes - 2008
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2008. The denominator is the latest mid-year population estimate (May 2009 release) for females ages 15-17 in Montana in 2008.

a. Last Year's Accomplishments
In state fiscal year (SFY) 2009, there were 359 births to females aged 15-17 and only 2 births to females under the age of 15. From 1995 to 2007, the United States teen birth rate, for 15-19 year old females, declined by approximately 23%. During the same time period in Montana, the teen birth rate, for 15-19 year old females, declined by 12%. In 2007, 20 states had teen birth rates lower than Montana's.

The Women's and Men's Health Section (WMHS) maintained contracts and provided technical assistance with 14 Delegate Agencies (DAs), offering services in 28 locations representing all 56 Montana counties. DAs ensured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, education information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on

family size and income, also ensured the affordability of these reproductive health services and supplies. In SFY 2010, the DAs served an estimated 7,331 adolescents and also provided specific outreach projects designed for adolescents at high risk for teen pregnancy and birth.

WMHS Program Specialist (PS) coordinated with a Health Education Specialist (HES), and Maternal and Child Health (MCH) Epidemiologist to distribute information to local DAs on current teen pregnancy rates and trends in the 2010 Annual Report and 2010 Teen Pregnancy Report. http://www.dphhs.mt.gov/PHSD/Women-Health/pdf/pregnancyreport.pdf

The HES organized a statewide campaign for Teen Pregnancy Prevention Month in May. Outreach packets were created that included a press release, sample letter and updated teen pregnancy rates for Montana. The State Family Planning Information and Education Committee (SFPIEC) met in June 2010 to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through outreach campaigns and toolkits provided by HES.

The HES met with the Regional Training Advisory Committee (RTAC), to evaluate DAs and Region VIII Title X agencies training needs, and the March 2010 Training focused on adolescents, clinicians, and front desk staff. The HES participated in Region VIII family planning training on Reproductive Health Education in April 2010; Denver CO. The focus was on reaching adolescents through social networking.

The Office of Population Affairs (OPA) distributed funds to WMHS which allocated it to DAs for expanding male services; the Bozeman Teen Outreach & Pregnancy Prevention Project (ended May 2010); dispensed highly effective and emergency contraceptives; and expanded services targeting low income women and men, including adolescents.

WMHS supported Planned Parenthood of Montana's efforts in teen pregnancy prevention and statewide teen pregnancy coalition. Staff attended a presentation during the Montana Public Health Association Conference. WMHS continues to provide information to the public on teen pregnancy rates in Montana.
WMHS disseminated information through the online newsletter which included funding opportunities, upcoming trainings and events, and information for Title X agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WMHS continues to provide reproductive health services, technical assistance, and educational and outreach materials	X		X	X
2. WHMS distributes an on-line newsletter for all the DAs, to provide updated information on teen pregnancy rates and other relevant information		X	X	X
3. Meet and discuss materials and family planning priorities with the SFPIEC				X
4. WMHS provides toolkits for 4 educational campaign's: Let's Talk Month, Get Checked MT, Sexual Health Awareness Month, and Teen Pregnancy Prevention Month		X	X	
5. Delegate agencies provide public education and outreach on comprehensive reproductive health care services that include how to prevent unintended pregnancy			X	
6.				
7.				
8.				
9.				

10.				

b. Current Activities
WMHS contracts with 14 DAs, representing all 56 MT counties. The DAs provide reproductive health services, technical assistance, and educational and outreach materials to residents.

WMHS distributes information to local DAs on current teen pregnancy rates and trends on a yearly basis and during a conference in November 2010.

SFPIEC meets on a yearly or as needed basis to review and plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits.

The Nurse Practitioner (NP) meets with RTAC, evaluating DAs and Region VIII Title X agencies training needs, and the March 2011 training focused on clinicians and motivational interviewing with adolescents and lesbian, gay, bisexual, transgender, questioning, and intersexed individuals. NP participated in Region VIII training on Reproductive Health Education in May 2011.

OPA funding is distributed to DAs for expanding male services; dispensing highly effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS received a grant to address teen pregnancy prevention utilizing evidenced based curriculum. The Request for Proposal was issued in April 2011. WMHS disseminates information through the online newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies. See the attached Action Guide.
An attachment is included in this section. IVC_NPM08_Current Activities

c. Plan for the Coming Year
Women's and Men's Health Section (WMHS) will contract and provide technical assistance with 14 Delegate Agencies (DAs), offering services in 28 locations representing all 56 MT counties. DAs will ensure that women and men of reproductive age, including adolescents, have access to comprehensive reproductive health care, education information, and services that include how to prevent unintended pregnancy. The agencies' sliding fee schedules will be based on family size and income. The sliding fee schedules will also ensure the affordability of these reproductive health services and supplies.

WMHS Program Specialist (PS) will continue to coordinate with HES, and MCH Epidemiologist to distribute information to local DAs on current teen pregnancy rates and trends on a yearly basis. SFPIEC meets on a yearly or as needed basis to review and to plan family planning priorities: Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and "Get Checked MT" HIV awareness through outreach campaigns and toolkits provided by HES.

HES will meet with RTAC, evaluating DAs and Region VIII Title X agencies training needs in fall 2011.

WMHS will continue to seek funding from the Office of Population Affairs for teen pregnancy prevention through the Personal Responsibility and Education grant. Trainings for sub-grantees will be conducted in fall 2011.

Curriculum training will cover Reducing the Risk for high school age population, and Drawing the Line for middle school population.

OPA funding will continue to be distributed to DAs for expanding male services; dispensing highly

effective & emergency contraceptives; and expanding services targeting low income women and men, including adolescents.

WMHS will continue to disseminate information through the on-line newsletter including funding opportunities, upcoming trainings and events, and information for Title X agencies.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	40	40	46	46	46
Annual Indicator	45.9	45.9	45.9	45.9	45.9
Numerator	4693	4693	4805	4773	4915
Denominator	10225	10225	10468	10398	10707
Data Source			05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment	05 06 Statewide OH Study, OPI 3rd Grade Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	46	46	46	46	46

Notes - 2010
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2009-2010 school year from the Montana Office of Public Instruction.

Notes - 2009
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2008-2009 school year from the Montana Office of Public Instruction.

Notes - 2008
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2006-2007 school year, from the Montana Office of Public Instruction.

a. Last Year's Accomplishments
During the 2009 -- 2010 school year, 91 schools conducted voluntary Basic Screening Survey (BSS) of children enrolled in public schools across Montana. The survey found that 39% of 3rd graders screened had received protective sealants on at least one permanent molar tooth. This does not meet the Healthy People 2010 goal of 50 percent.

The summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed to oral health stakeholders. It was also made available to the public on the Family and Community Health Bureau (FCHB) Oral Health website http://www.dphhs.mt.gov/PHSD/family-health/oral-health/family-oralHealth-index.shtml

The FCHB Oral Health (OH) program produced oral health educational materials which provide age-appropriate materials for teachers of children in grades 1-5. Each section focuses on one grade level and provides a summary of objectives and resources as well as talking points, handouts, coloring pages, games, illustrations, and lessons. Topics include the importance of teeth and oral hygiene, tooth development, tooth decay and prevention, importance of sealants and nutrition. Allmaterials are available on the FCHB Oral Health website http://www.dphhs.mt.gov/PHSD/family-health/oral-health/family-oralHealth-index.shtml

The FCHB OH program received a Grants to States to Support Oral Health Workforce Activities award from HRSA for developing a 5-year strategic plan (which will include implementing school-linked sealant programs), increasing number of schools which provide dental career education, and increasing the dental workforce in Montana.

The FCHB offers the Open Wide program (online oral health education program) to child care providers, WIC staff and school nurses. Upon completion of the Open Wide program participants are eligible for 2 continuing education credits from Montana's Early Childhood Project. In Calendar Year 2010 over 144 participants received this training and over 12,315 toothbrushes were distributed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Voluntary Basic Screening Survey			X	
2. Summary report on Montana's "2005-2006 Oral Health Study for Montana's Third Grade and Head Start Children" was finalized and distributed				X
3. Oral health educational materials			X	
4. Open Wide program				X
5. grant award from HRSA for oral health workforce activities				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Grants to States to Support Oral Health Workforce Activities allows for partnering with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The Oral Health Program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The Oral Health Program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start was increased and a new, uniform dental exam form was drafted for use by all participating Head Start programs in the state. This new form will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

The Oral Health Program will release a report summarizing the accomplishments and challenges of the Access to Baby Child Dentistry (ABCD) program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

School-specific reports on school-based oral health screenings conducted in the 2008-2009 and 2009-2010 school years will be distributed to participating schools and oral health screeners.

c. Plan for the Coming Year

The Grants to States to Support Oral Health Workforce Activities is a three year grant; therefore allowing the Oral Health Program to continue their partnership with Montana State University, Area Health Education Center to increase dental recruitment and retention efforts for the state and to develop and present dental career education modules for high school students.

The OH program will continue to review and update educational materials. The materials will be promoted in communications to school nurses, public health partners, school officials and other interested parties.

The OH program will continue to offer the Open Wide program which provides oral health education to child care providers, WIC staff, and school nurses.

Collaboration with Head Start will continue to implement use of a new, uniform dental exam form which will allow for analysis of oral health data by site and provide valuable information to communities seeking to address oral health issues.

The OH Program will release a report summarizing the accomplishments and challenges of the ABCD program. Individual reports will be available for the participating health centers and a comprehensive report will be released to the general public.

School-specific reports on school-based oral health screenings conducted in the 2010-2011 school year will be distributed to participating schools and oral health screeners.

The OH Program will continue to seek funding to implement school-linked dental sealant/varnish programs.

The OH Program will seek to work closely with the one county health department selected NPM 9 for the coming year. See the attachment.

An attachment is included in this section. IVC_NPM09_Plan for the Coming Year

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	4.4	4.3	4	6	6
Annual Indicator	6.2	5.6	6.2	5.6	5.6
Numerator	11	10	11	10	10
Denominator	177559	177577	178565	179583	179583
Data Source			MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	5.4	5.4	5	5	5

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
Denominator data are from the updated July 1, 2009 census estimates for the population of 0-14 year olds in Montana (May 2010 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Offive of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

Notes - 2008
Denominator data are from the updated July 1, 2008 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

a. Last Year's Accomplishments
The rate of deaths due to motor vehicles among children 14 years and younger continues to hover around 6 per 100,000. Motor vehicle deaths are one of the leading causes of death for

Montanans of all ages, and they become the leading cause and outpace other causes around 6-12 years of age.

In April 2010, the Infant Child & Maternal Health Section (ICMHS) became a part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The Fetal, Infant, and Child Mortality Review (FICMR) Coordinator was available as a resource via phone, email, traditional mail, or in person. The state FICMR coordinator shares pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators. The FICMR Coordinator participates on the Injury Prevention Coalition and the Emergency Medical Services for Children (EMSC), each charged with addressing preventable injuries.

The state FICMR Coordinator maintained contact with local FICMR Coordinators to assist with death certificate attainment, technical assistance and best practices for review and prevention. Local FICMR teams reviewed child deaths and implemented community activities related to prevention of motor vehicle deaths. Eleven County Health Departments reported a prevention activity pertaining to the prevention of deaths due to motor vehicle accidents. Activities included car seat and safety belt checks, an education campaign about "blind spots" to prevent accidents while backing up a vehicle, coordinated efforts to educate children and youth about drinking and driving, distracted driving and ATV safety, as well as motor vehicle safety while working on the farm or Hutterite colony.

One county selected NPM 10 as its focus and conducted activities to help decrease the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

The State FICMR Team no longer meets due to budget cuts.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A FICMR newsletter addressing current safety practices related to seatbelt use, car seats, helmet use and public awareness to watch for kids playing by cars			X	
2. Coordination with Healthy Mothers, Healthy Babies to promote access to car seats		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The FICMR Coordinator continues to support state and community injury prevention efforts by providing educational meetings/trainings and continues to be a resource via phone, email or through in-person contact and shares prevention information with local coordinators. Current journal articles and information related to infant and child death prevention, specific to motor vehicle safety, car seat and seat belt use are sent electronically to local coordinators.

The FICMR Coordinator attended the National Conference for Child Death Review at the Center for Disease Control in Atlanta, GA. FICMR is currently evaluating the use of the CDR reporting

tool, with the intention of participating in the National CDR data collection system to better understand child deaths, including those caused by motor vehicle accidents.

The FICMR Coordinator attends quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The FICMR Coordinator is a member of the Western Regional State Child Death Review Coordinators to address deaths to motor vehicle accidents, specific to rural/frontier states.

The FICMR Coordinator works with the MCHC Supervisor, MCH Epidemiologist, Vital Statistics, Injury and Prevention Coordinator, and other members of the Injury Prevention Coalition.

c. Plan for the Coming Year

The FICMR Program will continue to support community and state efforts in targeting the rate of deaths to children aged 14 and younger caused by motor vehicle crashes. The plan to target the rate of deaths caused by motor vehicle crashes is to 1) work collaboratively with local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to target motor vehicle crashes, and 3) develop resources and tools to better understand why motor vehicle crashes occur and what prevention activities and/or policies will reduce rates in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of deaths due to motor vehicle crashes by focusing on motor vehicle and transportation safety at the local FICMR coordinator training and meetings. Unintentional motor vehicle traffic crashes and unintentional other land transport are the leading causes of death among Montana youth. Goals are to implement local policies to address motor vehicle safety and enforce safety on the road. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to motor vehicle crashes. The FICMR Coordinator will assist in the sharing of practices and prevention activities to assure coordination and collaboration between counties.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator is a member of the Safe States Alliance and will participate in trainings.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to deaths of children aged 14 years and younger caused by motor vehicle crashes.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective	26	29	54	54	57
Annual Indicator	49.3	52.1	52.9	58.6	55.4

Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	57	57	58	58	58

Notes - 2010
The data reported for 2010 are National Immunization Survey data for children born in 2007. The data are not yet final. The confidence interval for this rate is +/- 7.7.

Notes - 2009
The data reported for 2009 are National Immunization Survey data for children born in 2006. The confidence interval for this rate is +/- 6.4.

Notes - 2008
The data reported for 2008 are National Immunization Survey data for children born in 2005. The data are final. The confidence interval for this indicator is +/- 6.1.

a. Last Year's Accomplishments
The MSPIRIT computer system has been rolled out for over a year. The system is still evolving as new partners are added and changes and modifications are made to the system. Data reporting is now being reviewed as a complete year's information is available.

The state Breastfeeding Coordinator (BC) worked with the MSPIRIT Users Subcommittee on modifying data fields and layout of the system's breastfeeding reports. This work will continue into the current year.

Two local program staff attended the USDA "Loving Support" breastfeeding training. They presented a pared down version of the training at the WIC Day of the Spring Public Health Conference (SPHC) in April 2010. The sessions build staff competencies for promoting and supporting breastfeeding. This included using the advantages of the breastfeeding food packages in conjunction with that promotion and support. These sessions and two others at the SPHC were eligible for Continuing Education Units (CEUs) with recognized breastfeeding organizations.

An additional four local programs were awarded Breastfeeding Peer Counselor grants for FFY 2010. They will continue with grants in FFY 2011. Three of the programs, Gallatin, Flathead and RiverStone represent about 20% to 25% of our annual participation. The Northern Cheyenne WIC Program also was awarded a grant, expanding the program to a second American Indian local program in Montana. The extra training funds were used to train staff as Certified Lactation

Counselors or to attend breastfeeding conferences.

Additional Breastfeeding Peer Counselor Program funds were earmarked for a training intended for the Breastfeeding Peer Counselors (BPC) and their supervisors. The training was carried out in December 2010. (see attached)

The weekly WIC newsletter was utilized to provide information about various breastfeeding conferences and trainings. This method allowed distribution of the information to not only direct service local WIC staff, but also to their supervisors and other interested parties.

The BC continued to be active in the Montana State Breastfeeding Coalition and attended the United States Breastfeeding Committee's 3rd National Conference for State/Territory/Tribal Breastfeeding Coalitions.

Montana implemented the Farm Direct Program which combines redemption activities of the WIC Fruit and Vegetable benefit and the WIC Farmers' Market Nutrition Program (FMNP) benefit. Authorized farmers selling their own locally grown produce sign one agreement and can redeem both benefits at any location where they normally sell their produce. The agreement is for three years with annual training. The authorized produce list is the same for both types of benefits. (See attached)

The What Incredible Choices Toolkit, a nutrition education tool kit emphasizing farmers' markets, was developed. Training for this toolkit was provided at the 2010 SPHC. The toolkit was also posted on the Montana WIC webpage at http://wic.mt.gov and at http://wicworks.nal.usda.gov/nal under shared resources.
An attachment is included in this section. IVC_NPM11_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Breastfeeding Peer Counselor Funding, Tech Assist to Locals	X			
2. Monitoring of Four BPC				X
3. Involvement with MT State Breastfeeding Coalition				X
4. Use of in-house newsletter to communicate training opportunities				X
5. Determined standards for new automated system and breastfeeding dyad food package assignment				X
6. Training on new food package including new breastfeeding food packages and relationship of breastfeeding level and supplemental formula, Loving Support (breastfeeding support)				X
7. Ordered breast pumps for distribution by local programs		X		
8.				
9.				
10.				

b. Current Activities
Hill, Lewis and Clark, and Silver Bow counties are starting the WIC Breastfeeding Peer Counselor Program (BPCP). They will provide BPC services to approximately 400 more pregnant or breastfeeding women. In the 2011 BPCP local contracts, the local programs were given three measurable indicators from which to choose two to report for their program. The three choices were: 1) percent of pregnant women contacted by a breastfeeding peer counselor, pre- and post-data for the year; 2) percent of women who have more than 3 actual contacts with a breastfeeding peer counselor during the fiscal year; or 3) percent of women exclusively

breastfeeding (WIC definition) at 3 months post delivery during the fiscal year. Training for BPCP and the BPC Supervisors was held November 30th and December 1st.

The State BC will be revising the BPCP monitoring tool due to the changes in monitoring with the implementation of the MSPIRIT automated system.

Announcements of upcoming breastfeeding conferences and trainings are included in the weekly WIC newsletter e-mail to all WIC staff and interested parties.

Montana joined the Western States Contracting Alliance (WSCA) breastpump contract. It is unknown at this time if food funds will be available to purchase breastpumps, but WSCA was available to join and in the current contract had several options of breastpumps available.

The BC participates in the Montana State Breastfeeding Coalition.

c. Plan for the Coming Year

Montana plans to maintain the 12 Breastfeeding Peer Counselor Projects at the local level. The statistical measures the local programs are to submit at the end of 2010 contract will be reviewed and analyzed. Subsequent year's activities will be measured against the benchmark to evaluate improvement.

The BC is planning to attend the Loving Support Training to be held in Denver in November 2011. She is also planning to attend the US Breastfeeding Committee Conference in August 2012. The information garnered from these trainings, especially the Loving Support Training will be used in future trainings for the BPC and their supervisors. Method of delivery of trainings will be determined based on available funding.

Work with the Reports Subcommittee of the MSPIRIT Users Group will continue. The committee has submitted requests to fix a number of reports and also enhancement requests. The changes made as a result of these requests will be reviewed as completed and the committee will determine if they are acceptable.

The BC plans to continue to participate in the Montana State Breastfeeding Coalition.

Three local health departments will focus on NPM 11 in FY 2012. See the attachment.
An attachment is included in this section. IVC_NPM11_Plan for the Coming Year

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	92	92	94	94	94
Annual Indicator	90.0	93.1	93.0	97.7	98.3
Numerator	11107	11403	11669	11448	11447
Denominator	12339	12249	12551	11719	11648
Data Source			MT newborn hearing screening system, Hi-Track	MT newborn hearing screening system, Hi-Track	Newborn Hearing Screening System and birth records

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	98.5	98.5	99	99	99

Notes - 2010
The numerator data source for this measure is HI*TRACK, the Newborn Hearing Screening Program software. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2010. It does not include births to Montana residents that occurred in hospitals out of state. As of 2009, the data reported are only for infants born in hospitals, to more closely correspond with the guidance for reporting on this performance measure. The data entered for 2010 are provisional.

Notes - 2009
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born in hospitals in Montana. The denominator is from the Montana Office of Vital Statistics and includes births that occured in Montana hospitals in 2009. It does not include births to Montana residents that occurred in hospitals out of state. The data were updated for the 2011 submission to reflect only hospital-based births.

Notes - 2008
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from the Montana Office of Vital Statistics and includes births to Montana residents that occured in Montana in 2008. It does not include births to Montana residents that occurred out of state. 12,178 (97%) of Montana's calendar year 2008 birth cohort were born in hospitals, approximately 2.5% were born with professional attendants, and .5% were born at home without professional attendants. Of those born in hospitals, 96% were screened prior to hospital discharge.

a. Last Year's Accomplishments
Montana's Universal Newborn Hearing Screening and Intervention (UNHSI) program continued to strive to achieve the 1-3-6 plan of the EHDI National Goals: Goal 1--all newborns will be screened for hearing loss before 1 month of age, preferably before hospital discharge; Goal 2--all infants who screen positive will have a diagnostic audiologic evaluation before 3 months of age; Goal 3--all infants identified with hearing loss will receive appropriate early intervention services before 6 months of age (medical, audiologic, and early intervention). The UNHSI program works in partnership with the Office of Public Instruction (OPI), the Montana School for the Deaf and the Blind (MSDB), local hospitals, midwives, and audiologists to achieve these goals.
Newborn hearing screening was performed at all 29 Montana birthing facilities and results were reported to the state UNHSI program for monitoring. For reporting purposes all newborn screening results were matched to birth certificate data. Upon referral, based on screening results, six pediatric audiologists reported diagnostic testing results to the program.

The MCH Block Grant objective for reporting year 2009 was 94% and 93.9% was achieved. Montana had 12,204 births in calendar year 2009. A total of 11,697 newborns received hearing screenings and of those babies 214 had "refer" results indicating the need for diagnostic evaluations. Of those infants whose screens indicated the need for follow-up, only 36 were documented to have received audiological diagnostic testing. Twenty-five of these infants were diagnosed as deaf or hard of hearing.

The UNHSI coordinator continued to provide technical assistance to hospitals, audiologists, and midwives to ensure compliance with state law. The program continued to provide tracking software and contracted for Help Desk services for use by birthing facilities and audiologists. The UNHSI Coordinator provided monthly feedback to all 29 birthing facilities on screening records to ensure that appropriate follow-up was completed based on screening results. A letter was sent to the primary care physician of each infant without a "pass" result on his or her hearing screening along with contact information for the five audiologists who are qualified to perform pediatric audiologic assessments in Montana.

The Montana Hearing Conservation Program audiologists under contract with OPI continued to provide free hearing screening to infants born outside of hospitals in accordance with the on-going agreement established between the UNHSI Coordinator and OPI.

All infants diagnosed as deaf or hard of hearing were electronically referred by the UNHSI Coordinator to the Montana School for the Deaf and Blind for monitoring and provision/coordination of intervention services. Children's Special Health Services (CSHS) and the MSDB also collaborated to develop program software within the CHRIS database to record and track services provided to children who are diagnosed as deaf or hard of hearing.

The UNHSI Coordinator publicized the 2009 Stars report for all birthing facilities. (See attached) The UNHSI Coordinator also provided feedback to midwives on their compliance with reporting requirements to the UNHSI program.
The UNHSI program provided local screening partners with newborn hearing screening brochures, posters, rack cards, and screening report forms containing milestones for language development for distribution to the parents prior to discharge. Program educational materials were distributed to pediatricians, family practice doctors, and midwives.

UNHSI Grant funding supported 30-second advertising spots on cable television in the seven largest service areas to increase awareness of the importance of newborn hearing screenings. The CDC's Early Hearing Detection and Intervention (EHDI) grant funding continued to support UNHSI program efforts to provide intensive quality assurance on all screening data by conducting on-site visits with all local partners who screen newborns or perform diagnostic assessments over the three-year period of 2008 through 2011. EHDI grant funding was also used to enhance the CHRIS database system with the goal of increasing the program's ability to track diagnoses, continuing assessments, and intervention services for deaf or hard of hearing children.
An attachment is included in this section. IVC_NPM12_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with birth certificate data				X
2. Continue to provide tracking software and contract for Help Desk technical assistance for use by birthing facilities and audiologists.				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate the results to screening and assessment partners statewide.			X	

4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and the Blind within six months of each child's birth.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The UNHSI program continues to collect hearing screening data on all infants born in Montana's birthing facilities each month. Feedback is provided to make sure that all screening information is submitted and that there is follow up on infants who do not pass inpatient screens or infants not receiving an inpatient screen. The program continues to work with out-of-state hospitals to access screening information on infants who have been transferred out of state.

Primary care physicians are contacted by the UNHSI coordinator to ensure follow-up on infants with "refer" screening results. Audiologist's submissions of diagnostic testing results are monitored to make sure any infant diagnosed with a hearing loss is electronically referred to the MSDB.

Quality assurance visits to hospitals continue to ensure proper documentation and reporting to the UNHSI program and evaluate facility screening protocols. Feedback is provided to improve reporting accuracy and compliance with state law.

Educational materials continue to be provided to program partners.

Funding continues to help provide updated equipment to hospitals.

To obtain funding to continue program activities, the UNHSI coordinator submitted grant applications for the UNHSI grant and the EHDI grant.

c. Plan for the Coming Year
The Montana UNHSI program will continue collecting data on all infants receiving newborn hearing screenings and providing feedback to birthing facilities, midwives, and audiologists to increase the number of infants receiving newborn hearing screenings and ensure that each infant who has a "refer" result on inpatient screening receives appropriate follow-up as indicated. Electronic referrals to the Montana School for the Deaf and the Blind will continue to be made for all infants who receive a diagnosis of deaf or hard-of-hearing upon receipt of a signed consent form indicating that the parents wish to have the infant's information shared.
Collaboration with hospitals, audiologists, midwives, primary care providers, OPI, and MSDB will ensure the UNHSI program continues to increase the number of infants who are receiving newborn hearing screenings in Montana. Input from a hearing champion from the Montana American Academy of Pediatrics and a volunteer parent advisor will be valuable in planning and evaluating future program goals and objectives.

The program will continue to provide reporting software for newborn hearing screening results and diagnostic testing to all Montana birthing facilities and pediatric audiologists--and will continue the process of upgrading hospitals to the current version of the software. Help Desk access for all users of the software will continue to be funded by the program to ensure accurate documentation of all newborn hearing screenings and any diagnostic testing results.

Funding from the UNHSI grant will be used to help provide updated screening equipment to hospitals and diagnostic equipment will be purchased for an audiologist in eastern Montana to

help increase access to services for infants in that part of the state.

The UNHSI program will continue to provide educational materials to hospitals, midwives, pediatricians, and family practice doctors.

On-site quality assurance visits will continue--including hospitals, audiologists, and midwives-- in order to monitor and improve reporting of screening results and diagnostic testing. Targeted on-site QA visits will be done with a team including the UNHSI coordinator, the MSDB consulting audiologist, a nurse consultant, and an MCH epidemiologist. The QA visits will provide comprehensive evaluation of data and procedures to identify challenges and successes in meeting the reporting requirements required by state law.

The UNHSI coordinator will attend statewide meetings including the annual Montana Hospital Association meeting, the Montana AAP meeting, and the annual Montana Audiology Guild meeting to increase awareness of the issues identified through 2010 newborn hearing screening data analysis. The UNHSI coordinator will report on the causes of loss to follow-up (LTFU) and suggest solutions as well as get input from these partners on this issue.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	16	16	14	13	11
Annual Indicator	16.2	14.8	14.2	11.9	11.1
Numerator	37000	35686	34417	28863	26868
Denominator	228000	241206	242716	241672	242453
Data Source			US Census CPS Table Creator II	US Census CPS Table Creator II	US Census; CPS Table Creator II
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	11	11	10	10	10

Notes - 2010
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2010 for health insurance coverage in 2009. The data for 2010 will be collected in 2011 and become avilable in 2012 for health insurance coverage in 2011. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2009
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2009 for health insurance coverage in 2008. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

Notes - 2008
The data source for this is the US Census CPS Table Creator II. The CPS data were collected in 2008 for health insurance coverage in 2007. The numbers reflect the estimated percent of children under 19 years of age who were not covered by public or private health insurance.

a. Last Year's Accomplishments
The percent of children in Montana without health insurance varies slightly depending on the data source, but the Henry J. Kaiser Family Foundation: State Health Facts (2008-2009) indicates 11 percent of MT children were without health insurance compared to 10 percent nationally.

The Healthy Montana Kids (HMK) program was implemented October 1, 2009 and expanded eligibility to families under 250% of the federal poverty level. The Healthy Montana Kids Plan covers kids by: 1) expanding eligibility for the Children's Health Insurance Program (CHIP) and Medicaid children's coverage; 2) offering premium assistance to eligible parents who add children as dependents to their employer-sponsored health plan; 3) using "enrollment partners" to actively enroll eligible kids; and 4) using federal matching funds to pay most of the cost. The HMK program has two levels: Healthy Montana Kids Plus (same program as Medicaid) and Healthy Montana Kids (same program as CHIP). HMK is a free or low-cost health coverage plan. The plan provides health coverage to eligible Montana children and teenagers up to age 19. A child can qualify for HMK based on family size and income. This program not only increased the number of children in the state with health insurance, but also reduced the number of children who fell through the gaps between Medicaid and CHIP eligibility. Healthy Montana Kids and Healthy Montana Kids Plus were intended to facilitate continuous coverage of children whose families are under 250% of the federal poverty level, whereas previously coverage may have fluctuated if children's eligibility shifted from Medicaid to CHIP or vice versa.

In SFY 2009, Healthy Montana Kids (CHIP) had 25,298 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

The HMK program continued its efforts to increase the number of children enrolled in the Healthy Montana Kids program. Children with health coverage have greater access to preventive and acute health care services. HMK continued to work towards its goal of improving the health of Montana families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Montana Kids provided quality, comprehensive insurance coverage for Montana children		X		
2. Healthy Montana Kids expanded and coordinated coverage for uninsured children under Medicaid and CHIP		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids.

In October 2010, the Primary Care Office (PCO) collaborated with the Primary Care Association (PCA) and HMK to create information about MT's Community Health Center locations and the National Health Service Corps sites, which was distributed in a HMK monthly mailing to families. The contact information includes how to access one of these medical care providers. (See the attachment)

Children's Special Health Services (CSHS) monitors the number of children with special health care needs (CSHCN) served by CSHS with a source of health care coverage. CSHS refers, links, and counsels families to available sources of health care coverage such as Medicaid, State Children's Health Insurance Program, Caring for Children Program and Comprehensive Health Association of ND (CHAND) as well as to other assistance programs.

WIC continues to ensure that families are referred to Healthy Montana Kids or Healthy Montana Kids Plus.

An attachment is included in this section. IVC_NPM13_Current Activities

c. Plan for the Coming Year

CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Both parties will continue to work towards their shared goal of improving the health of Montana children.

The FCHB will use the National Survey of Children's Health to establish a baseline for any local health departments selecting National Performance Measure 13. The FCHB will also assist any local health departments selecting this performance measure in developing and implementing activities which will increase the percentage of children with health insurance and/or participating in Healthy Montana Kids.

Families will be required to apply for Healthy Montana Kids or Healthy Montana Kids Plus prior to eligibility determination for CSHS services. This will allow families to have more comprehensive healthcare coverage. Families who apply for HMK or HMK+ who have a CSHCN will be offered referral to services through the CSHS program.

The Primary Care Office (PCO) will continue to work with the Primary Care Association and Healthy Montana Kids on updating the information about Montana's Community Health Center locations and the National Health Service Corps sites for ongoing distribution in HMK mailings.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	25	30	30	29	31
Annual Indicator	32.5	33.6	33.7	33.3	40.0
Numerator	3629	3706	3876	3957	5099

Denominator	11169	11029	11492	11878	12744
Data Source			WIC Program Enrollment	WIC Program Enrollment	WIC Program Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	31	31	31	31	31

Notes - 2010
The source is the Montana State WIC Program. Data are for FFY 2010. The increase in the indicator for 2010 is believed to be due to a change in data systems. Some records may be duplicated. As a result, the objective was not increased based on the 2010 data. Montana will reassess the objective next year when a full year of data from the new data system will be available.

Notes - 2009
The source is from the MT State WIC Program. Data are for FFY 2009.

Notes - 2008
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '08 starting 01/01/08 and ending 12/31/08. The numerator reflects all children with risk codes 16 and 17.

Although there was a fairly large increase in the percent of children ages 2 to 5 years receiving WIC services with BMI at or above 85th percentile from 2005 to 2006, since then there have been smaller but steady percentage increase reported by the WIC Program. The large change from 2005 to 2006 could be related to changes in the way the data are collected.

a. Last Year's Accomplishments
In 2009 Pediatric Nutrition Surveillance System (PedNSS) Montana data, the percent of children equal to or greater than age 2 to 5 years who had a Body Mass Index at or above the 85th percentile and less than the 95th percentile was 15.8. The percentage of children equal to or greater than age 2 to 5 years who were defined as overweight by being at or greater than the 95th percentile was 12.5. This is only a slight change from the 2008 PedNSS Montana data which was 16.0 and 12.4 respectively.

The PedNSS data submitted by WIC is collected from the automated system which is now MSPIRIT. This system identifies the anthropometric risks of at-risk of overweight and overweight using CDC growth criteria. A report in MSPIRIT will also count the number of participants that were assigned these nutrition risk codes at certification.
Local WIC staff collected children's weight and height measurements at each certification, which determined the child's body mass index (BMI). Parents of a child determined to be overweight or obese status were provided additional WIC counseling as requested by the family at future WIC appointments.

The new WIC food packages have been in place for over a year. They continue to reflect the Dietary Guidelines with more fiber-rich choices, fruits and vegetables, and low-fat foods. In

recent investigation of redemption rates, it was noted that the WIC fruit and vegetable benefits redemption rate was lower than expected, even with the option to use them with local farmers. (see attached Food List)

Montana implemented the Farm Direct Program which combines redemption activities of the WIC Fruit and Vegetable benefit and the WIC Farmers' Market Nutrition Program (FMNP) benefit. Authorized farmers selling their own locally grown produce sign one agreement and can redeem both benefits at any location they normally sell their produce. The agreement is for three years with annual training. The authorized produce list is the same for both types of benefits. Farm Direct was established to allow participants to be able to cash their WIC Fruit and Vegetable benefits with local authorized farmers. The WIC FMNP was already in place, but if both programs operated separately then it would be more difficult for participants and farmers to remember the requirements for each program. The reduction in different "rules" was to encourage participants to utilize their local farmers, especially during the seasons when fresh produce was so readily available. This also resulted in an increase in locations where participants could redeem either benefit.

An infrastructure grant was implemented at the end of September 2010. Local programs were given small grants to promote fruits and vegetables, thermal grocery bags with a fruit and vegetable theme and a Healthy Harvest Cookbook. The product items could be used in nutrition education, outreach and as incentives.

Other funds from the infrastructure grant were utilized to develop and produce a toolkit for local program staff with a theme of "What Incredible Choices." The toolkit was provided to all local programs for use in promoting fruits and vegetables.

Eat Right Montana (ERM) newsletters and child nutrition conference information were distributed through the weekly WIC newsletter which is sent to all direct services local program staff, their supervisors and other interested parties.

An additional four local programs were awarded Breastfeeding Peer Counselor grants for FFY 2010. They will continue with grants in FFY 2011. Three of the programs, Gallatin, Flathead and RiverStone represent about 20% to 25% of our annual participation. The Northern Cheyenne WIC Program was also awarded a grant and expands the program to a second American Indian local program in Montana.

Additional Breastfeeding Peer Counselor Program (BPCP) funds were earmarked for a training intended for the Breastfeeding Peer Counselors (BPC) and their supervisors. The training was carried out in December 2010.
A WIC Futures Study Group (WFSG), composed of lead local public health officials, local program, and state WIC Staff, was formed during 2008 and met in May 2010. The WFSG discussed a number of topics including, the current and future WIC funding allocation formula, program direction, and how to provide quality WIC services into the future. The minutes of this meeting are available at http://wic.mt.gov
An attachment is included in this section. IVC_NPM14_Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local staff weigh and measure infant and child participants	X			
2. VENA questions determined and incorporated into automated system				X
3. Continued funding for BPC	X			
4. Training of staff on Loving Support (breastfeeding support)				X
5. WIC Futures Study Group activities				X

6. Distribution of ERM Healthy Families Newsletter			X	
7. Involvement with Chronic Disease/Obesity Task Force and with the MT State Breastfeeding Coalition				X
8. Train staff on significant changes to new food packages, less fat, more whole grains, fruits, vegetables and fiber				X
9.				
10.				

b. Current Activities

WIC staff and a contractor will be researching nutrition education materials available as on-line activities or other media.

Infants and children continue to be weighed and measured for WIC certification and when appropriate.

Children at a BMI greater than the 85th percentile may be referred to a Registered Dietitian for high-risk nutrition follow-up.

The BPCP expanded to 12 local programs with the addition of programs in Hill, Lewis and Clark, and Silver Bow WIC Programs. This increases access to a breastfeeding peer counselor for pregnant and breastfeeding WIC participants to about 2700 statewide.

Data on the WIC fruit and vegetable benefit and the WIC FNMP benefit redemption rate at grocers and farmers was given to local programs. Local programs were encouraged to find ways to best promote and educate their participants on the use of the two types of benefits.

This summer is the 2nd season for Farm Direct which authorizes farmers selling Montana grown produce at farmers' markets, roadside stands and other locations where they sell their produce. Increased consumption of fresh fruits and vegetables can replace less nutrient dense foods in a participant's diet.

Funding to develop local staff training for competencies in VENA was not received due to the Federal continuing resolution this fiscal year. Plans are to repeat the request next year. The competencies would include discussion on child weight issues.

c. Plan for the Coming Year

Montana WIC will purchase Food for Thought: Eating Well on a Budget, a nutrition education packet and DVD created to engage both kids and parents, for use by local staff with participants. It will provide information on how families can shop wisely and make healthy food choices on a budget; the value and importance of breastfeeding; the healthy quality and variety of the WIC food packages; and easy-to-follow recipes the family can enjoy. The packet and DVD were created as a joint project between Sesame Street and the National WIC Association.

Montana WIC will implement one year certifications for children. This may result in less frequent weighing and measuring between certification because with the implementation of this option, the delivery method of nutrition education to low-risk participants is being reviewed along with various types of resources. Resources being reviewed will also include those addressing healthful eating and being physically active.

The redemption rates of the WIC Fruit and Vegetable Benefit and the WIC FMNP Benefit were reviewed. The rates were lower than expected whether at grocery stores or farmers. At the Family and Community Health Conference (FCHC) WIC Day, local program staff were encouraged to develop nutrition education methods and activities that would work in their community to promote the use of these two benefits. The redemption rates will be monitored in Spring 2012.

Montana WIC plans to work with the Nutrition and Physical Activity Program on joint projects that promote physical activity, healthy eating behaviors and lifestyle choices. This is in the early stages of planning and definite projects have not been selected.

Two county health departments selected NPM 14 for FY 2012. (see attached)

An attachment is included in this section. IVC_NPM14_Plan for the Coming Year

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	15	15	14	14	14
Annual Indicator	15.9	15.9	15.0	13.4	13.4
Numerator	1668	1668	1893	1630	1630
Denominator	10509	10509	12595	12155	12155
Data Source			Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics	Live birth data, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	13	13	13	13	13

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator does not include women with unknown smoking status in the third trimester. This indicator is believed to be an under-report of the actual number of women smoking during the last trimester.

Notes - 2008
These data are collected and reported by trimester of pregnancy, not month of pregnancy. 2008 is the first year smoking status has been available from the birth record by time period of pregnancy. The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. This number is believed to be an under-report of the actual number of women smoking during the last trimester.

a. Last Year's Accomplishments
In April 2010, the Infant Child & Maternal Health Section (ICMHS) became part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The Public Health Home Visiting (PHHV) Nurse Consultant position now reports to the MCHC Section Supervisor. The PHHV Nurse Consultant continues to support state and community PHHV sites by serving as a resource via phone, electronically and with in-person contacts. Current information related to smoking rates and cessation during pregnancy is forwarded to PHHV home visitors.

The Family and Community Health Bureau (FCHB) funded 16 PHHV programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. The remaining 15 PHHV programs continued to promote the Montana Tobacco Quit Line and other tobacco cessation resources to tobacco using women who were pregnant or primary care givers of infants.

Funding for the six enhanced PHHV sites ended in December 2009. Five of the six enhanced PHHV sites continued to be PHHV sites but one site ceased to provide PHHV activities. The five continuing sites were bound by the contract discussed in the following paragraph.

In the state PHHV site contracts which began on 7/1/2010 with 15 sites, PHHV home visitors were asked to assess and monitor the High Risk Pregnant Woman's (HRPW) smoking and other tobacco use status by following "…The U.S. Preventive Services Task Force (USPSTF) Tobacco Cessation Counseling Guide sheet assessment tool at least at intake for the HRPW and High Risk Infant (HRI)." The home visitors had been taught about the USPSTF guidelines in three webinars presented by the Montana Tobacco Cessation program during January and February 2010. PHHV clients received information on the effects of tobacco during pregnancy from the PHHV home visitors.

The PHHV Nurse Consultant collaborated with Montana Tobacco Use Prevention Program (MTUPP) to provide information for PHHV staff and other public health staff on tobacco cessation strategies for pregnant women.
PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources were collected 1 July-31 December 2009 by all of the PHHV sites. Thirty-four percent of PHHV women (n=109) self-reported smoking during pregnancy. Twenty-three percent of smoking PHHV women (n=37) reported smoking during the last three months of pregnancy. Thirty-five percent (n=13) reported quitting smoking during pregnancy. The findings for each site were compared to the data submitted from all sites and a report was given to each site during the visits discussed below.*

Between 2/22/2010 and 8/4/2010, all sites received a nurse consultant visit. In addition to feedback about the data submitted electronically as discussed above, record reviews were done on randomly selected client charts. One item reviewed by the site visitor was whether or not it was noted in each chart that the pregnant woman or infants' primary care giver had tobacco use assessed. In pregnant women charts, 83% of the charts clearly noted tobacco assessment was done. The record review findings were sent to each visited PHHV site.
*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
SFY 2011 contracts include the requirement, under services to be provided, "Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy." Home visitors are asked to follow The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet at intake of clients to assess tobacco use and plan intervention for those who use tobacco.

The FCHB funds 15 PHHV programs, which promote the Montana Tobacco Quit Line through information and referrals for their pregnant women and infant/family units. The PHHV home visitors also refer clients to other community cessation programs. (see attached)

Since SFY 2010, all the PHHV sites are visited at least once during each SFY year by a PHHV Nurse Consultant.
PHHV sites enter PHHV client data elements into a common electronic data system. Data on outcomes related to pregnant women using tobacco products, cessation of tobacco use, and referrals to cessation resources are collected by all of the PHHV sites. Quality assurance checks are conducted and site-specific reports are compiled and sent back to each site.

The PHHV clients receive information from the PHHV home visitor on the effects of tobacco and secondhand smoke during pregnancy and on the infant.

The PHHV Nurse Consultant collaborates with MTUPP to provide information for PHHV staff and other public health staff on tobacco cessation strategies for pregnant women.
An attachment is included in this section. IVC_NPM15_Current Activities

c. Plan for the Coming Year
During the coming year, Montana will administer funding to local health departments for home visiting efforts. The state funded Public Health Home Visiting (PHHV) administration of funds from DPHHS to fourteen county and one tribal health department will continue and the Affordable Care Act (ACA) Maternal Infant Early Childhood Home Visiting (MIECHV) program will begin in one county using the Parents as Teachers (PAT) evidenced-based model for home visiting.

Both of the home visiting programs will assess for and intervene in smoking by adult clients. The assessment methods are discussed below in the description for each program. Referrals are usually made to the Montana Tobacco Usage Prevention Program (MTUPP) another DPHHS entity. Other tobacco cessation sites are the recipients of referrals from home visitors and sometimes clients, based on individual assessment, are referred to psychological treatment services or private physicians for smoking cessation.

The state contract with the fourteen county and one tribal health department will require the site visitors to assess tobacco use and intervene with adults who smoke in situations where fetuses and children may be compromised. The proposed contract language is as follows: Encourage HRPW/PHHV clients to abstain from smoking and other tobacco use at or before the third trimester of their pregnancy through the end of their pregnancy and make referrals for cessation as needed.

Home visitors are required to assess and intervene using the United States Prevention Task Force guidelines and the contract language is as follows:
For each HRPW client the following required, standardized screening and/or assessment tool …

will be administered and the results will be entered into the client's PHHV … electronic record

Cessation Counseling Guidesheet at least at intake for the HRPW and High Risk Infant (HRI). The U.S. Preventive Services Task Force Tobacco Cessation Counseling Guidesheet is located at:
http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

ACA MIECHV funds will allow the selected high-risk community to serve approximately 50 families. MIECHV benchmarks and constructs require gathering of data related to maternal child health and pregnancy outcomes.
… States are required to collect data on all constructs listed below each benchmark area… Improved Maternal and Newborn Health [Benchmark]… Constructs that must be reported for this benchmark area (all constructs must be measured that are relevant for the population served)… Definition of quantifiable, measurable improvement… For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs improvement is defined as rate decreases over time.

At this time assessment tools for measuring tobacco usage are being considered. Tobacco usage by pregnant women will be measured pre- and post-natally with an expected outcome of reduction of smoking by the cohort over time.

Three county health departments selected NPM 14 for FY 2012. See attachment
An attachment is included in this section. IVC_NPM15_Plan for the Coming Year

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	10	10	9	9	11
Annual Indicator	19.2	16.3	11.9	13.4	13.4
Numerator	13	11	8	9	9
Denominator	67811	67574	67074	67302	67302
Data Source			MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates	MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12.5	12.5	12	12	11.5

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator includes deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2009 census estimates for the population of 15-19 year olds in the state (May 2010 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

Notes - 2008
The numerator include deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2008 census estimates for the population of 15-19 year olds in the state (May 2009 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

a. Last Year's Accomplishments
Local Fetal, Infant, and Child Mortality Review (FICMR) teams reviewed child deaths and implemented community activities related to the prevention of youth suicide.

The FICMR Coordinator was available as a resource via phone, email, traditional mail or in person. The FICMR Coordinator shared pertinent prevention information, current journal articles and information received from national sources related to infant and child death prevention with the local coordinators via email. The FICMR Coordinator participated on a number of committees, i.e. Injury Prevention Coalition and the Emergency Medical Services for Children (EMSC), each charged with addressing preventable unintended and intended injuries.

The Family and Community Health Bureau (FCHB) collaborates as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana.

The FCHB sustained FICMR activities with several training opportunities. The FICMR coordinator training, held February 2010, included FICMR review basics, determining preventability of deaths, death certificate information and a mock case review for 13 attendees. During this face-to-face meeting, there was discussion on the current review tool, how to keep local team members involved and an open discussion on prevention activities and lessons learned. The attendees were allowed the opportunity to ask questions about the mortality review process and how to submit a FICMR review.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with writing the final report, "A Summary of Mortality Reviews Conducted in 2005-2006." The report, which highlighted evidenced-based best practices and prevention activities in Montana including youth suicide, was distributed to the local FICMR coordinators and is available online on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-index.shtml

Three counties selected NPM 16 as their focus and conducted activities to help reduce the rate of suicide deaths among youths aged 15 through 19.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordination with the State Suicide Prevention Program		X		
2. Best practices for suicide prevention at the local FICMR training				X
3. Data collected on suicide rates and discussed in program summary report				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FICMR Coordinator supports state and community FICMR injury prevention efforts by providing educational meetings/trainings and serves as a resource via phone, email or in-person contact. Current journal articles and information related to youth suicide prevention are sent electronically to local FICMR coordinators.

The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator shares prevention information with local coordinators to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator coordinates with key stakeholders in injury prevention and the University system to discuss suicide prevention policies and implementation practices.

The FICMR Coordinator continues utilizing coordinator trainings and meetings to educate coordinators on how to accurately complete the FICMR data reporting form. The FICMR Coordinator attended the Child Death Review National Conference and is a member of a regional coalition, of which youth suicide is a priority.
FICMR data collection and the National Child Death Review (CDR) database were reviewed and future FICMR reports will be evaluated using the National CDR database. FCHB plans on making the change during Federal Fiscal Year 2012.

Local FICMR Teams continue to review child deaths and implement community activities related to prevention of youth suicide.

c. Plan for the Coming Year
The Fetal, Infant and Child Mortality Review (FICMR) Program will continue to support community and state efforts in targeting suicide prevention among youths aged 15 through 19. The plan to target the rate of suicide deaths is to:
1) work collaboratively with local coordinators, especially those in counties experiencing higher rates,
2) work collaboratively with other agencies to target youth suicide, and
3) develop resources and tools to better understand why suicides occur and what prevention activities and/or policies will reduce rates in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of suicide by focusing on suicide prevention at the local FICMR coordinator training and meetings. Suicide is a leading cause of death among Montana youth. Goals are to strategize around prevention activities, access to resources (i.e training from the state suicide prevention specialist) and evaluate evidence-based models for effectiveness in future implementation. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of youth suicide. The State FICMR Team will no longer meet due to budget cuts.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Suicide prevention, targeted to rural areas, is a topic for the coming year. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to youth suicides.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	91	91	91	91	75
Annual Indicator	81.8	86.8	73.0	64.1	64.1
Numerator	126	138	108	82	82
Denominator	154	159	148	128	128
Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	65	65	65	66	66

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2009, Montana had three level III facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

Notes - 2008
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2008, Montana had three level 3 facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

a. Last Year's Accomplishments
In April 2010, the Infant Child & Maternal Health Section (ICMHS) became part of the Maternal and Child Health Coordination section (MCHC) of the FCHB. The PHHV Nurse Consultant

position reports to the MCHC Section Supervisor.

The Family and Community Health Bureau (FCHB) funded 16 Public Health Home Visiting (PHHV) programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. The remaining 15 PHHV programs continued to implement programs directed towards fulfilling Montana Code Annotated 50-19-311 which includes "low birth weight prevention."
Funding for the six enhanced PHHV sites ended in December 2009. Five of the six continued providing PHHV services.

The PHHV home visitors assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provided clients with education on the importance of starting prenatal care during the first trimester and continuing prenatal care until birth of the baby. Pregnant women were assessed for risks that have the potential to affect pregnancy outcomes and provided ongoing education on the signs of preterm labor.

PHHV pregnant clients without health insurance coverage were assisted with the presumptive eligibility process, thus allowing early access to prenatal care and/or referral to Medicaid by PHHV home visitors.

PHHV sites began entering client data into the common electronic data system as of July 1, 2009. Data on outcomes related to adequacy of prenatal care using the Kotelchuck Index and referrals to health care resources is being collected. Of the 71 reports for women who had intake and outcome in the PHHV program during the time period 7/1/2009 through 12/31/2009, ten percent (n=7) self-reported delivering an infant weighing less than 2500 grams.*

The FCHB staff collaborated with the following: March of Dimes Montana Chapter (to focus on prematurity prevention), the Family Planning Programs in Montana (to counsel and refer clients with positive pregnancy tests to early prenatal care), and WIC providers (to refer pregnant clients to PHHV services and early prenatal care if needed).

Each of the 16 PHHV sites had quality assurance on-site visits between 2/22/2010 and 8/4/2010.
*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The PHHV Nurse Consultant supports state and community PHHV efforts as a resource via phone, email or in-person contact. Links to training and information related to pre-term labor prevention are shared with PHHV home visitors.

FCHB continues to fund 15 PHHV programs, which uphold the Montana Initiative for the Abatement of Mortality Act (MCA 50-19-311) and provide information and referrals to pregnant women to prevent low birth weight. The PHHV home visitors assist clients to enter into early and continuous prenatal care.
Since SFY 2010, PHHV sites are visited at least once a year by a PHHV Nurse Consultant. The sites are monitored for their compliance with program requirements and the FCHB staff provides technical assistance as needed. Site visit quality assurance forms include chart review to monitor the appropriateness of referrals.

PHHV visitors distribute materials on detection of pre-term labor to pregnant women. Women are then empowered to fully participate in medical prenatal care by contacting the provider if signs of preterm labor occur.

c. Plan for the Coming Year
During the coming year, Montana will administer funding to local health departments for home visiting efforts. The state funded Public Health Home Visiting (PHHV) administration of funds from DPHHS to fourteen county and one tribal health department will continue and the Affordable Care Act (ACA) Maternal Infant Early Childhood Home Visiting (MIECHV) program will begin in one county using the Parents as Teachers (PAT) evidenced based model for home visiting.

Both of the home visiting programs will assess for and intervene to prevent low birth weight. The assessment methods are discussed below in the description for each program.

The state contracts with the fourteen county and one tribal health department will require the site visitors to assess pregnant women for the risk of delivering a low birth weight infant. The PHHV programs will be asked to do surveillance and assessment of county births with the infant weighing less than 2500 grams. The contract-proposed language is as follows:

Educate HRPW clients on the importance of carrying a pregnancy to 39 to 40 weeks and the signs and symptoms of early labor. In the event the HRPW is evidencing signs, the home visitor must facilitate access to medical evaluation.
With the implementation of an updated DPHHS web-site with an intended audience of the general public, the site can contain a listing of Montana hospitals and nurseries with various NICU levels. The usefulness of the site will be dependent upon explanation to the general public about the necessity to prevent low weight infant births.

DPHHS will continue to partner with agencies such as the March of Dimes, to alert the public of the need to avert low birth weight infant deliveries.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	85.4	85.9	84.5	73	74
Annual Indicator	82.4	82.1	71.3	73.1	73.1
Numerator	10302	10213	8982	8061	8061
Denominator	12499	12437	12595	11029	11029

Data Source			Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics	Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	75	75	75	75	75

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. 10% of births had unknown timing of prenatal care initiation. The "unknowns" are not included in the denominator. A new birth record format was implemented in 2008, which changed the way the timing of prenatal care initiation was calculated. Thus, the measure for 2008 and onward may not be comparable to previous years.

Notes - 2008
2008 data for this measure should not be compared to previous years. The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. The decrease in the timing when prenatal care relates to changes in the way the data are collected on the new birth record format implemented in 2008. Also, 6% of records reported "unknown" timing of prenatal care initiation, a large increase from the approximately 2% unknown reported in previous years.

a. Last Year's Accomplishments
Funding for the six enhanced Public Health Home Visiting (PHHV) sites ended in December 2009. Five of the six enhanced PHHV sites continued to be PHHV sites but one site ceased to provide PHHV activities. The Family and Community Health Bureau (FCHB) funded 16 PHHV programs until 7/1/2010 when Northern Cheyenne declined a continuing contract. Fifteen PHHV programs continued. Between 2/22/2010 and 8/4/2010, all sites received a nurse consultant visit.

The PHHV home visitors assessed and monitored the status of prenatal care during home visits and other face-to-face contacts with PHHV clients. PHHV home visitors provided the PHHV client with education on the importance of early and adequate prenatal care to achieve healthy pregnancy outcomes and continuing prenatal care until birth of the baby.

All PHHV pregnant clients without health insurance coverage were assisted with the presumptive eligibility process, thus allowing access to early prenatal care and/or referral to Medicaid by PHHV home visitors. While the number of women assisted with the presumptive eligibility process is not known, reports to the FCHB indicated 82% of women reported for the time period 7/1/2009

to 12/31/2009 had Medicaid at the time of discharge from the program.

PHHV sites began entering PHHV client data elements into the common electronic data system as of July 1, 2009. Data on self reports of initiation of and number of prenatal care visits were collected 1 July-31 December 2009 by all of the PHHV sites. Seventy percent (n=76) of women served by the PHHV sites during the six month time period were reported to have begun prenatal care during the 1st trimester, 18% (n=19) of women served during the six month time period were reported to have started prenatal care in the 2nd trimester, and four percent (n=4) started during the 3rd trimester. The information was unknown for five percent (n=5). Data was missing for 3 of the 109 pregnant women reports. A total of 627 prenatal medical visits were reported by 109 women during the six month reporting period with the range of number of visits per woman being 0 to 20.*

*Represents data collected by local PHHV sites and submitted to DPHHS for clients who had intake and outcome during 1 July 2009 through 31 December 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of PHHV to high-risk pregnant women and infants	X			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Nurse consultation for PHHV sites occurs within the Maternal and Child Health Coordination Section (MCHC) of the FCHB. The PHHV Nurse Consultant position reports to the MCHC Section Supervisor. The PHHV Nurse Consultant supports state and community PHHV efforts via phone, email or in-person contacts. Current information related to the importance of early prenatal care is provided to PHHV home visitors.

The FCHB funds 15 PHHV programs which provide home visiting services to high risk pregnant women to promote healthy pregnancy outcomes. (see attached)

The PHHV home visitors assess and monitor the status of prenatal care during home visits and other face-to-face contacts with PHHV clients and promote the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana. PHHV home visitors provide the PHHV client with education on the importance of starting prenatal care as early as possible and continuing throughout the pregnancy.

The FCHB collaborates with local public health providers, physicians, March of Dimes, Family Planning Programs, and other MCH partners on issues surrounding delivery of very low birth weight infants and to counsel and refer clients with positive pregnancy tests to health care resources.

PHHV pregnant clients without health insurance coverage are assisted by PHHV home visitors with the presumptive eligibility process for Medicaid, thus facilitating access to early prenatal care and other healthcare resources.

An attachment is included in this section. IVC_NPM18_Current Activities

c. Plan for the Coming Year
As of SFY2012, DPHHS will be contracting with Lake County Health Department to implement an evidenced-based Parents as Teachers program funded by Maternal Infant Early Childhood Home Visiting (MIECHV) ACA HRSA funding. Lake County will begin working with pregnant women as early in pregnancy as possible; early and continuous prenatal care will be one goal for all pregnant women. In their proposal for use of the ACA MIECHV funding, Lake County wrote as their objective "Increase the number of pregnant women who receive prenatal care in the first trimester."

The above objective is a restatement of the Montana MIECHV Updated State Plan in which the state-wide goal is as follows: "Identify and provide comprehensive services to improve outcomes for families who reside in at risk communities" and the objective is stated: "Increase the number of pregnant women who receive prenatal care in the first trimester."

Montana DPHHS will continue to fund, with state funds, fifteen sites for home visiting. The fifteen sites are a continuation of the Montana Initiative for Abatement of Mortality in Infant (MIAMI) project which has existed since 1989. The legislation which grounds the MIAMI project is Montana Code Annotated (MCA) 50-19-311. The MIAMI project legislation contains a description of the services to be provided and one is "…assistance to low-income women and infants in gaining access to prenatal care…" so the contracts with local health departments have and will continue to have reference to MIAMI home visitors promoting early continuous prenatal care. In the contract proposed for SFY 2012 between DPHHS and local health departments, the following language will appear as the first service in the list to be provided by the local projects:

The FCHB will ensure that each HRPW/PHHV client receives early and continuous prenatal care.

D. State Performance Measures

State Performance Measure 1: *The percent of children with cleft lip and/or palate receiving care in interdisciplinary clinics.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					89.7
Numerator					26
Denominator					29
Data Source					CSHCN Program-CHRIS system
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	90	90	90	90	90

Notes - 2010
Data are for federal fiscal year (FFY) 2010. The data reflect the number of infants born during FFY 2010 and identified as having a cleft lip and/or palate by the Children's Special Health Services (CSHS) Section (the state CSHCN program), who were seen in a cleft/craniofacial clinic.

a. Last Year's Accomplishments

The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address Children with Special Health Care Needs. The new state performance measure will be MT State Performance Measure (SPM) 01: the percent of children with cleft lip and/or palate receiving care at interdisciplinary clinics.

State Performance Measure 01 addresses Montana's MCH Priority Area of CSHCN which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

All children with clefts/craniofacial conditions were invited to participate in team clinics. Families diagnosed prenatally with a cleft condition were also invited to clinics to meet team providers and have feeding and treatment questions answered. Primary care providers (PCP) were encouraged to refer clients to clinic. Children were followed from birth throughout childhood and adolescence at periodic intervals. Clinics provided families with anticipatory guidance and opportunity to network with other families.

Team care provides children and families with a "one-stop-shopping" type of care where multiple providers are available during one visit for evaluation and consultation. CSHS bills for these clinic services and underwrites the cost of the clinics for those who do not have health coverage or are inadequately insured.

During FFY 2010, 238 individuals were seen in Cleft/craniofacial clinics for a total of 248 visits. The overall show rate for FFY 2010 was 54% with ranges between clinics sites of 48% to 68%.

During FFY 2010 CSHS was approved by the American Cleft Palate Association as an approved Cleft Palate and Craniofacial Team. As part of this process CSHS completed an analysis of speech outcomes post surgical repair of children followed in cleft clinics. (See attached) The results of this study indicated that cleft clinic speech assessment documentation is not adequate to evaluate surgical results. With the limited documentation, over half of the children with palate repairs had age-appropriate to mild impairment of speech intelligibility upon entering school, which is a goal of the Montana Cleft/craniofacial Team.

An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Team care was offered to all newborns with cleft/craniofacial conditions.	X			
2. CSHS completed analysis of speech outcomes post surgical repair of children followed in cleft clinics				X
3. Primary care providers encouraged to refer clients to clinic.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Team providers continue to offer Cleft/craniofacial clinic services to children with cleft and craniofacial conditions. Between clinic follow-up is being facilitated by expanded social work hours through the regional pediatric specialty clinic sites.

Ongoing analysis of clinic attendance rates is performed quarterly. The Montana team faces the same issues as other cleft teams with regard to the dropping attendance of older children. We have continued to explore this issue and are discussing options for more involvement of older children in their treatment plans and care decisions. Team members are sensitive to school schedules, sports, and other activities the children and youth are involved with, however "treatment fatigue" continues to impact final outcomes. CSHS plans to continue working with PCPs to encourage attendance. In addition, team coordinators are committed to making contact with families soon after birth a priority.

Attached is a draft of "Prevalence and Identification of Cleft Lip and Palate in Montana". This assessment is expected to be completed in the upcoming year.

See attached "Early Identification of Cleft Lip and Palate in Montana".

Twenty-nine newborns with cleft lip and or palate were invited to attend a Montana Cleft clinic during FFY 2010. Of those, 2 have not attended a clinic to date, although they have had multiple invitations. One is scheduled to attend a clinic in September; this child was just recently referred to the clinic.

An attachment is included in this section. IVD_SPM1_Current Activities

c. Plan for the Coming Year

Montana plans to continue to provide cleft/craniofacial clinics at accessible locations in the state to assure that families have access to team care. There has been some nurse coordinator turnover this past year so we are planning to have a coordinator training to assure that all team coordinators understand cleft standards of care and the sequencing of treatment. Training will also focus on feeding infants with clefts as feedback from families continues to emphasize this as a need.

We plan to implement a plan to have ongoing speech assessments provided by school and private therapists between clinic visits with a standardized assessment form. This project was identified as a current year activity, which we were unable to complete due to staffing demands.

In partnership with the Maternal and Child Health Epidemiology Unit , CSHS will complete the assessment of "Prevalence and Identification of Cleft Lip and Palate in Montana".

State Performance Measure 2: *The percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator					24.4
Numerator					10386
Denominator					42631
Data Source					Medicaid
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**

Annual Performance Objective	1	1	1	1	1

Notes - 2010
Data are from the Montana Medicaid Program (Healthy Montana Kids Plus) and include all children enrolled in Medicaid during July 1, 2009 through June 30, 2010 (State Fiscal Year 2010) who received an oral evaluation by a dentist.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health (MCH) Needs Assessment process resulted in the creation of a new state performance measure to address children's oral health. The new state performance measure will be MT State Performance Measure (SPM) 02: the percent of Medicaid clients 0 through 6 years of age who have had a dental screening during the year.

State Performance Measure 02 addresses Montana's MCH Priority Area of children's oral health which falls under the Public Health and Safety Division's (PHSD) Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All available data was reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The state Oral Health Program is working with the state Medicaid office to improve the oral health of Medicaid clients 0 through 6 years of age. In addition to monitoring Medicaid data, the state Oral Health Program added two questions to the Behavioral Risk Factor Survey (BRFSS) pertaining to oral health. These questions will allow more insight into the availability and access to dental care for a broader range of Montanans.

All available data will be reviewed and used to direct discussions with stakeholders regarding access to dental care issues for Medicaid families.

The state oral health program is also working closely with Head Start programs across the state to standardize the dental exam forms, collect more state-level data and promote establishing a dental home for all children enrolled in Head Start programs.

c. Plan for the Coming Year
The PHSD is exploring possible implementation of a fluoride varnish program for high-risk communities, in which primary medical providers and clinical staff will be trained to perform oral

assessments, provide fluoride treatments, and help find dental homes for children 0 through 6 years of age. Clients and their families will be referred by physicians to the Medicaid care coordination program for assistance with locating a dental home.

The Oral Health Education Specialist will work closely with the one county health department that selected SPM 2. See the attachment.
An attachment is included in this section. IVD_SPM2_Plan for the Coming Year

State Performance Measure 3: *The percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator					11.3
Numerator					22
Denominator					194
Data Source					Linked Medicaid-birth certificate data.
Is the Data Provisional or Final?					Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	12	12	12	12	12

Notes - 2010
Data are from birth certificate and Medicaid paid claims for 2008 and 2009 births.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health (MCH) Needs Assessment process resulted in the creation of a new state performance measure to address maternal health. The new state performance measure will be MT State Performance Measure (SPM) 03: the number and percent of Medicaid clients who have gestational diabetes and have their blood glucose measured during the time period of six weeks to six months postpartum.

State Performance Measure 03: addresses Montana's MCH Priority Area of maternal health which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Maintain programs that provide services to women (pre-pregnancy, prenatal and post-natal) and children."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All available data will be reviewed and used to direct discussions within the Public Health and Safety Division (PHSD) regarding improved follow up care and health education services for Medicaid clients with gestational diabetes.				X
2.				
3.				
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
All available data will be reviewed and used to direct discussions within the Public Health and Safety Division (PHSD) regarding improved follow up care and health education services for Medicaid clients with gestational diabetes.

c. Plan for the Coming Year
The Family and Community Health Bureau (FCHB), Office of Epidemiology and Scientific and Support (OESS), Medicaid, and the Montana Cardiovascular Disease and Diabetes Prevention Program of the Chronic Disease Prevention and Health Promotion Bureau will collaborate to promote improved follow up care and health education services for Medicaid clients with gestational diabetes mellitus (GDM). This collaboration will also improve state-level data collection and reporting for Medicaid clients with gestational diabetes.

A possible intervention which the PHSD may undertake is to work with Medicaid data to track birth records for Medicaid clients with GDM. As soon as a follow up visit is filed for the client with GDM, the Medicaid office will notify the OESS as to where the client is receiving follow up care. The MDP and OESS will prepare and send a letter from the state medical officer to the provider of care for the client. This letter will notify the provider that this client recently had GD and will also provide a reminder that this client needs to have her blood glucose measured within six weeks to six months postpartum. In addition, the provider will be informed of any available lifestyle intervention programs to which clients may be referred. Program information, locations and contact information are available to providers through a printed brochure or the website: http://www.dphhs.mt.gov/PHSD/Diabetes/DiabetesPrevention.shtml.
Medicaid claims data will be used to track whether targeted women have a blood glucose evaluation within the designated timeframe.

State Performance Measure 4: *The rate of death to children 0 through 17 years of age caused by unintentional injuries.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				13.6	13.6
Numerator				30	30
Denominator				219828	219828
Data Source				Death certificate data	Death certificate data
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	13	13	12	12	12

Notes - 2010
The data reported are 2009 data. 2010 data were not available at the time of grant submittal.

Notes - 2009
Includes deaths to children 1 through 17 years of age with ICD10 causes V01-X59 and Y85-Y86.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address unintentional injuries. The new state performance measure will be MT State Performance Measure (SPM) 04: the rate of death to children 0 through 17 years of age caused by unintentional injuries (per 100,000).

State Performance Measure 04 addresses Montana's MCH Priority Area of unintentional injury prevention which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Reduce unintentional injuries and death among Montanans from motor vehicle occupant crashes, falls, poisoning, and other preventable injury-related risk factors."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings related to children 0-18 years of age				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Fetal, Infant, and Child Mortality Review (FICMR) program is part of the Maternal and Child Health Coordination section (MCHC) of the Family and Community Health Bureau (FCHB). The FICMR Coordinator supports state and community FICMR injury prevention efforts by providing educational meetings/trainings and serving as a resource via phone, email or in-person contact. Information related to unintentional injuries and death due to motor vehicle crashes, falls, drowning, unsafe sleep conditions and poisoning are disseminated to the local FICMR coordinators and state partners.

The FICMR Coordinator attends quarterly EMSC Advisory and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings related to children 0-18 years of age. The FICMR Coordinator shares prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator attended the National Conference on Child Death review and collaborates with regional FICMR Coordinators to address best practices related to Injury Prevention.

FICMR data collection and the National Child Death Review (CDR) database were reviewed and future FICMR reports will be evaluated using the National CDR database. FCHB plans on making the change during Federal Fiscal Year 2012.

Local FICMR Teams continue to review child deaths and implement community activities related to motor vehicle death prevention.

c. Plan for the Coming Year

The Fetal, Infant and Child Mortality Review (FICMR) Program will continue to support community and state efforts in targeting unintentional injuries. The plan to target the rate of unintentional injuries is to 1) work collaboratively with local coordinators, especially those in counties experiencing higher rates, 2) work collaboratively with other agencies to address unintentional injuries, and 3) develop resources and tools to better understand why unintentional injuries occur and what prevention activities and/or policies will reduce rates among children 0 through 17 in Montana.

The FICMR Coordinator will work collaboratively with local coordinators to address the rate of deaths due to unintentional injuries by focusing on motor vehicle transport, drowning, poisoning, fires and burns, firearm safety, as well as falls at the local FICMR coordinator training and meetings. Unintentional injury deaths are the leading causes of death among Montana residents, 0-17 years of age. Goals are to implement local policies to address unintentional injuries. Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of deaths attributed to unintentional injuries. The State FICMR Team will no longer meet due to budget cuts, but experts on related issues will be utilized in developing activities and creating policies.

The FICMR Coordinator will continue to attend quarterly EMSC Advisory Meetings and State Injury Prevention Coalition meetings to discuss prevention strategies and analyze data findings. The State FICMR Coordinator will share prevention information with local coordinators via email or trainings to assist local FICMR teams in developing community level prevention activities. The FICMR Coordinator is a member of the Safe States Alliance and will participate in trainings.

The FICMR Coordinator is a member of the Western-States Child Death Review Coalition, a group that meets via conference call once a month to strategize around a variety of topics. Plans to implement the Child Death Review (CDR) Data Reporting system (1/1/2012) will improve national and local data, as well as prevention activities, related to deaths of children 0 through 17 of age, caused by unintentional injuries.

The FICMR Coordinator will work closely with the three county health departments that selected SPM 4. See the attachment.

An attachment is included in this section. IVD_SPM4_Plan for the Coming Year

State Performance Measure 5: *The precent of women who smoke during pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator				16.0	16.0
Numerator				1949	1949
Denominator				12158	12158
Data Source				Birth certificates	Birth certificates
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	15	15	14	14	14

Notes - 2010
Data for 2010 were not available at the time of grant submission. Data will be updated when 2010 birth data are final.

Notes - 2009
Women with "unknown" reported for smoking during pregnancy (1% of resident live births) are not included in the denominator.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address maternal and infant health. The new state performance measure will be MT State Performance Measure (SPM) 05: the percent of women who smoke during pregnancy.

State Performance Measure 05 addresses Montana's MCH Priority Area of maternal and infant health which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase the percentage of healthy Montana babies (under 1 year) by promoting: the baby-on-back sleep position and safe environments; and adequate prenatal care to include breastfeeding education, smoking cessation and substance abuse interventions for pregnant women."

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. PHHV contracts included the wording "Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy"				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Contracts in effect for state fiscal year 2011 (SFY 10) between DPHHS and 15 Public Health Home Visiting (PHHV) sites contained the following wording: 1) The Contractor agrees to provide the following services for the purposes of addressing the following outcomes as agreed upon by the PHHV Reassessment Project: Increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 2) For each high risk pregnant woman (HRPW)/PHHV client the following required, standardized screening and/or assessment tools will be administered and the results will be entered into the client's PHHV/HDIS electronic record: The U.S. Preventive Services Task Force (USPSTF) Tobacco Cessation Counseling Guide sheet assessment tool at USPSTF least at intake for the HRPW and high-risk infant (HRI). The Tobacco Cessation Counseling Guide sheet assessment tool is located at: http://www.ahrq.gov/clinic/uspstf09/tobacco/tobaccosum2.htm

c. Plan for the Coming Year
As is consistent with the DPHHS PHSD mission statement "… improve and protect the health and safety of Montanans" the Public Health Home Visiting (PHHV) projects, through the signing

of the proposed contract for SFY 2011, will agree to " increase the percentage of H[igh] R[isk] P[regnant] W[omen] PHHV clients receiving PHHV services who quit smoking cigarettes at or before the third trimester of the pregnancy for which visits are being received and never smoke a cigarette again during this pregnancy".

From data gathered during SFY2010, the baseline for percentage change described above will be determined. PHHV sites began entering PHHV client data elements into a common electronic data system as of 1 July 2009. Data on outcomes related to pregnant women smoking, other tobacco use, cessation and referrals to cessation resources were collected 1 July-31 December 2009 by all of the PHHV sites. Thirty-four percent of PHHV women (n=109; N=488) self-reported smoking during pregnancy, Twenty-three percent of smoking PHHV women (n=37) reported smoking during the last three months of pregnancy. Thirty-five percent (n=13) reported quitting smoking during pregnancy. For quality feedback purposes, the findings for each site were compared to the consolidated data submitted from all sites and a report was given to each site so each site could evaluate whether or not efforts to reduce smoking were producing desired results. The same will be done during SFY2011 after the yearly data is submitted 15 August 2011 for the time period 1 July 2010 to 30 June 2011.

During the site visit to each of the fifteen sites by a nurse consultant, chart reviews are performed. One chart review item for pregnant women is to assess whether or not appropriate referrals were made based on the assessment data collected. In SFY 2010, each pregnant woman and primary care-giver of an infant was to be assessed using the United States Preventive Task Force (USPTF) tobacco use assessment guide. If the client is using tobacco, the home visitor is to follow the USPTF guide to assist the client in decreasing tobacco use.

A close relationship exists between the DPHHS PHHV administration and the Montana Tobacco Use Prevention Program (MTUPP) and the local PHHV home visitors often refer to MTUPP or other DPHHS sponsored tobacco use control programs located throughout the state. During record review on site visits to local PHHV sites, emphasis is given to documentation of referral of pregnant women who smoke to cessation services. If a sites data indicates a need for more diligence towards tobacco product discontinuation of clients, the nurse consultant discusses this disconnect with the local program and they brain-storm ways to increase emphasis on and discontinuation of tobacco products by women they are serving in their PHHV program. The emphasis will continue in SFY2012.

Three of the health departments that selected SPM 5 are PHHV contractors, the fourth is adjacent to one. See the attachment

An attachment is included in this section. IVD_SPM5_Plan for the Coming Year

State Performance Measure 6: *The percent of children 19-35 months of age who have received the 4th immunization in the diphtheria, tetanus, and pertussis (DTaP) series.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Performance Objective					
Annual Indicator			74.4	76	79
Numerator					
Denominator					
Data Source			National Immunization	National Immunization	National Immunization

			Survey	Survey	Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	80	80	80	80	80

Notes - 2010
Data are from the National Immunization Survey, July 2009-June 2010 tables. The confidence interval is +/-6.4

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.5.

Notes - 2008
Data are from the 2008 National Immunization Survey. The confidence interval is +/-6.2.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Diphtheria, Tetanus, and Pertussis. The new state performance measure will be MT State Performance Measure (SPM) 06: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Diphtheria, Tetanus, and Pertussis.

State Performance Measure 06 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria,Tetanus, Pertussis and other vaccine preventable conditions."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DPHHS, Immunization Section will partner with contractors to improve the immunization rate in Montana.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide with best practices to improve immunization rates at local health departments. (see attached)

The Public Health Home Visiting (PHHV) program assesses whether infants in the program receive their two, four and six month immunizations and the PHHV provider counsels the parent on the importance of continuing scheduled immunizations for the infant.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources. Interdisciplinary teams staffed by a pediatrician and/or public health nurse will review immunization status.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana.

An attachment is included in this section. IVD_SPM6_Current Activities

c. Plan for the Coming Year

The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:

• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg. Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

Four county health departments selected SPM 6. See the attachment.

An attachment is included in this section. IVD_SPM6_Plan for the Coming Year

State Performance Measure 7: *The percent of children 19-35 months of age who have received an immunization against varicella.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective					
Annual Indicator			77.7	77.5	81.2
Numerator					
Denominator					
Data Source			National Immunization Survey	National Immunization Survey	National Immunization Survey
Is the Data Provisional or Final?				Final	Provisional
	2011	**2012**	**2013**	**2014**	**2015**
Annual Performance Objective	82	82	83	83	83

Notes - 2010
Data are from the July 2009-June 2010 National Immunization Survey tables. The confidence interval is +/-6.2.

Notes - 2009
Data are from the 2009 National Immunization Survey. The confidence interval is +/-6.6.

Notes - 2008
The data are from the 2008 National Immunization Survey. The confidence interval is +/- 6.0.

a. Last Year's Accomplishments
The 2010 Maternal and Child Health Needs Assessment process resulted in the creation of a new state performance measure to address immunizations against Varicella. The new state performance measure will be MT State Performance Measure (SPM) 07: the percent of children 19-35 months of age who have received all age-appropriate immunizations against Varicella.

State Performance Measure 07 addresses Montana's MCH Priority Area of Immunizations which falls under the Public Health and Safety Division's Strategic Plan Health Improvement Priority "Increase childhood immunization rates for Diphtheria, Tetanus, Pertussis and other vaccine preventable conditions."

This performance measure was not established during this time period.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The DPHHS, Immunization Section will partner with				X

contractors to improve the immunization rate in Montana.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FCHB developed an Immunization Activity Guide with best practices to improve immunization rates at local health departments. (see attached)

The Public Health Home Visiting (PHHV) program assesses whether infants in the program receive their two, four and six month immunizations and the PHHV provider counsels the parent on the importance of continuing scheduled immunizations for the infant.

Children's Special Health Services (CSHS) will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources. Interdisciplinary teams staffed by a pediatrician and/or public health nurse will review immunization status.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana.
An attachment is included in this section. IVD_SPM7_Current Activities

c. Plan for the Coming Year
The FCHB will develop a qualitative survey for local health departments to assess state support for all performance measures including NPM 07.

The Affordable Care Act Home Visiting (ACA HV) and state Public Health Home Visiting (PHHV) programs will assess whether infants in the program receive their two, four and six month immunizations. The ACA HV and state PHHV providers will counsel parents on the importance of continuing scheduled immunizations for infants.

The CYSHCN program will assess children who attend some pediatric specialty clinics for required immunizations and refer them to the appropriate resources.

The WIC Program will continue to encourage parents and caregivers to obtain well childcare and refer participants to eligible programs. The WIC certification form includes a check-off box for the health care provider to indicate if the child is up-to-date on immunizations, which then enables the WIC nutritionist to reinforce the importance of obtaining missed immunizations.

The DPHHS, Immunization Section will partner with 53 contractors to improve the immunization rate in Montana. Contractor activities will consist of:
• Maintaining immunization records in the statewide immunization registry system.
• Coordinating and providing outreach and referrals for children identified by immunization information systems who are behind in their immunizations.
• Developing and implementing a protocol for reducing missed opportunities for vaccination (eg.

Review immunization records at every visit, or eliminate missed opportunities for simultaneous vaccination).
• Meeting quarterly with key internal partners to review data provided and discuss strengths and opportunities for improvement.
• Meeting quarterly with local vaccinations for children (VFC) providers to review the data reports provided by Department of Public Health and Human Services (DPHHS) and share best practices for increasing immunization rates.
• Maintaining records received from local schools for children entering kindergarten and 7th grade, review for completeness and accuracy, and follow up on children who are conditionally attending.
• Assessing immunization records of children enrolled in daycare settings for appropriate immunization status, and notify day care providers of children who are enrolled without appropriate documentation of immunization.
• Providing follow-up in the daycare settings for children not up-to-date as required for daycare attendance.
• Ensuring the perinatal hepatitis b prevention protocol is updated to include standards developed by the centers for disease control and prevention.
• Promoting delivery of vaccination services to underinsured adolescents.

One county health department will focus on SPM 7 in FY 2012. See the attached map.

An attachment is included in this section. IVD_SPM7_Plan for the Coming Year

E. Health Status Indicators

Introduction

The Health Status Indicators (HSIs) provide a description and overview of the resident Montana population. They are an opportunity for the state to review and consider the current rates and trends for crucial maternal and child health (MCH) issues, such as low birth weight, very low birth weight, and deaths due to various causes. They also allow the MCH program to assess how the data have been collected and reported in the past and consider how changes in data systems and limitations in data sources may affect the quality of what is reported.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	7.3	7.2	7.4	7.1	7.1
Numerator	911	895	931	870	870
Denominator	12499	12437	12595	12280	12280
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010

The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009

The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's low birth weight rate appears to have been gradually increasing. The low birth weight rate in 2000-2002 was 6.6 and the rate for 2006-2008 is 7.3.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	5.6	5.6	5.8	5.5	5.5
Numerator	676	671	706	657	657
Denominator	12092	12034	12203	11903	11903
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's singleton low birth weight rate appears to have been gradually increasing. The singleton low birth weight rate in 2000-2002 was 5.2 and the rate for 2006-2008 is 5.7.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	1.2	1.2	1.1	1.0	1.0
Numerator	149	144	144	127	127
Denominator	12499	12437	12595	12280	12280
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
Montana's very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The very low birth weight rate in 2000-2002 was 1.1 and the rate for 2006-2008 is 1.2.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.9	0.9	0.9	0.8	0.8
Numerator	106	103	111	92	92
Denominator	12092	12034	12203	11903	11903
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:

Montana's singleton very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The singleton very low birth weight rate in 2000-2002 was 0.8 and the rate for 2006-2008 is 0.9.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	10.7	9.6	11.8	11.1	11.1
Numerator	19	17	21	20	20
Denominator	177741	177688	178565	179582	179582
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Montana's death rate due to unintentional injury among children 14 and younger has remained fairly stable. Unintentional injury is a leading cause of death for Montanans of all ages. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Approximately 80% of the 2005-2006 unintentional injury deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, at least 90% of unintentional injury deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use by a caregiver, poor or inadequate supervision, and lack of use of available safety measures such as seatbelts or helmets.
In addition, as of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	5.6	5.6	6.2	5.6	5.6
Numerator	10	10	11	10	10
Denominator	177741	177688	178508	179541	179541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6-12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience.

In the majority of the 2005-2006 deaths the child was in a passenger vehicle, although the reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	43.1	43.2	43.4	38.0	38.0
Numerator	59	59	59	55	55
Denominator	136834	136424	136045	144746	144746
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data reported are for 2009. 2010 data were not available at the time of grant submittal.

Notes - 2009
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2010 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6- 12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience. reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010

Annual Indicator	169.7	256.9	211.8	217.8	217.8
Numerator	301	458	381	393	393
Denominator	177413	178268	179889	180465	180465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
The data are from 2009 and include Montana residents only. 2010 data were not available at the time of grant submittal. Data provided my the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
2008 data are from the hospital discharge data. The numerator includes non-fatal injuries to Montana residents only. The denominator is the census estimate of children 14 years and younger in 2008 (May 2009 version).

Narrative:
Prior to 2007, the data source for this indicator was the State Trauma Registry (STR), the most complete source of data on nonfatal injuries in the state at the time. However, the data from this source is considered to substantially underestimate of the actual rate of nonfatal injuries. Also, trauma registry data was not a good indicator of trends, as the data quality changed from year to year. For instance, in 2007 one of the large hospitals in the state did not report any data to the registry.

Since 2007, the data source for this indicator is hospital discharge data, a more complete source of data than the State Trauma Registry. The data reported for this indicator includes nonfatal injuries for Montana residents only.

Hospital discharge data reporting is not mandatory in Montana, does not include data from all hospitals, and does not include emergency department data. The hospital discharge data that are available do not in most cases include the ecodes required to assess the types of injuries treated. A bill introduced in the 2009 Montana legislature to make hospital discharge data reporting mandatory did not pass. However, a statewide injury prevention program was established, which will increase the focus on injuries and is expected to assist in improving the quality of hospital discharge data. A variety of injury prevention activities take place at the state and local levels, such as safety awareness education, Safe Kids/Safe Communities programs, and other activities targeted through various programs.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**

Annual Indicator	433.1	398.3	365.3	288.1	288.7
Numerator	767	710	657	520	521
Denominator	177112	178268	179844	180465	180465
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from July 1, 2009 census estimates, as estimates have not yet been released for 2010.

Notes - 2009
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Notes - 2008
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	2,273.7	2,150.2	1,909.4	1,577.9	1,444.9
Numerator	3114	2912	2592	2266	2075
Denominator	136959	135429	135746	143606	143606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Numberator data from Montana Department of Transportation Traffic Safety. Denominator data from July 1, 2009 census estimates, as estimates have not yet been released for 2010.

Notes - 2009
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Notes - 2008
Numerator data from Montana Department of Transportation Traffic Safety. Denominator data from census estimates. Updated for 2011 submission.

Narrative:
There has been a steady decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving. As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular. A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	22.1	23.5	27.7	24.6	24.6
Numerator	720	794	926	807	807
Denominator	32551	33850	33488	32789	32789
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
The data reported are 2009 data. Data will be updated for the September submission.

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2009. The denominator is from census estimates of Montana resident females 15-19 years of age in 2009 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 15-19 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Narrative:

The gradual increase in the chlamydia rate for 15-19 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	7.7	7.8	8.4	8.6	8.6
Numerator	1140	1158	1249	1292	1292
Denominator	147904	148467	149294	149491	149491
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
The data reported are 2009 data. Data will be updated for the September submission.

Notes - 2009
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). Reporting for 2009 may not be complete.

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (June 2010 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Narrative:
The gradual increase in the chlamydia rate for 20-44 year olds is believed to be due to improved case reporting and an increase in the sites that reported test results. Reporting for 2009 may not be complete.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12838	10920	275	1473	170	0	0	0
Children 1	49600	41738	1162	6069	631	0	0	0

through 4								
Children 5 through 9	58491	49826	1389	6576	700	0	0	0
Children 10 through 14	59536	51950	1228	5712	646	0	0	0
Children 15 through 19	68108	59753	1119	6546	690	0	0	0
Children 20 through 24	75498	67438	906	6150	1004	0	0	0
Children 0 through 24	324071	281625	6079	32526	3841	0	0	0

Notes - 2012
Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Data are from the 2009 census estimates (released in May 2010). Estimates for Native Hawaiian, more than one race, and other/unknown are not available.

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12255	583	0
Children 1 through 4	46782	2818	0
Children 5 through 9	55082	3409	0
Children 10 through 14	56555	2981	0
Children 15 through 19	65273	2835	0
Children 20 through 24	72885	2613	0
Children 0 through 24	308832	15239	0

Notes - 2012
Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Data are from the 2009 census estimates (released in May 2010).

Narrative:
The data source for this indicator is census estimates.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	2	1	0	1	0	0	0	0
Women 15 through 17	359	217	3	120	0	0	12	7
Women 18 through 19	906	614	1	230	3	0	34	24
Women 20 through 34	9656	8239	38	1008	24	6	177	164
Women 35 or older	1357	1150	0	92	79	0	18	18
Women of all ages	12280	10221	42	1451	106	6	241	213

Notes - 2012
Births to Pacific Islanders are included in "Asian" due to the format of the available data.

Births to Pacific Islanders are included in "Asian" due to the format of the available data.

Births to Pacific Islanders are included in "Asian" due to the format of the available data.

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**

Women < 15	2	0	0
Women 15 through 17	329	30	0
Women 18 through 19	854	52	0
Women 20 through 34	9401	310	0
Women 35 or older	1269	33	0
Women of all ages	11855	425	0

Notes - 2012

Narrative:
The data source for this indicator is live birth records from the Montana Office of Vital Statistics.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	72	50	1	16	0	0	4	1
Children 1 through 4	20	14	0	5	0	0	1	0
Children 5 through 9	13	11	0	2	0	0	0	0
Children 10 through 14	11	9	0	2	0	0	0	0
Children 15 through 19	55	37	0	16	0	0	2	0
Children 20 through 24	87	62	0	21	1	0	3	0
Children 0 through 24	258	183	1	62	1	0	10	1

Notes - 2012
Data are from 2009 death records for Montana residents. 2010 data were not available at the time of grant submission.

Due to the format of the available data, deaths to Pacific Islanders are reported under "Asian."

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	70	2	0
Children 1 through 4	17	3	0
Children 5 through 9	13	0	0
Children 10 through 14	11	0	0
Children 15 through 19	53	2	0
Children 20 through 24	84	3	0
Children 0 through 24	248	10	0

Notes - 2012

Narrative:
The data source for this indicator is death records from the Montana Office of Vital Statistics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	242453	205589	3373	14351	938	1078	17124	0	2010
Percent in household headed by single parent	29.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2010
Percent in TANF (Grant) families	2.8	1.6	4.2	22.6	0.8	0.5	0.0	0.0	2010
Number enrolled in Medicaid	66660	49353	773	15373	216	26	919	0	2010
Number enrolled in SCHIP	25493	17427	84	1502	107	28	2048	4297	2010
Number living in foster home care	2840	1468	80	1050	9	5	194	34	2010
Number enrolled in food stamp program	53436	41800	451	10774	148	76	187	0	2010
Number enrolled in WIC	29291	18051	161	5326	50	39	5664	0	2010
Rate (per 100,000) of juvenile crime	4727.1	4610.7	6255.6	11016.7	4797.4	0.0	0.0	0.0	2010

arrests									
Percentage of high school drop-outs (grade 9 through 12)	4.3	3.5	0.0	10.6	1.5	4.9	0.0	6.3	2010

Notes - 2012
Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Estimates for single parent households by race for 2010 do not appear to accurately reflect the population, thus only the total for single parent households is reported.

MT TANF Demographic Data. Data are for Federal Fiscal Y ear 2010.

The data are children 0 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pull by child's DOB, race and ethncity and are unduplicate count. Data source is MT Medicaid Querypath.

Data are from MT Healthy Montana Kids (CHIP) for 2010.

MT Supplemental Nutrition Assistance Program (SNAP) Data

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control data from 2010. Denominator data are from 2010 census estimates.

Other and unknown race category includes Black, Native Hawaiian/Pacific Islander. Data Source MT Office of Public Instruction. Numerator is a dropout count, denominator is enrollment count reported for 2009-2010 school year.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates, and the summary below focuses on the total numbers reported for 2007 and 2008 instead of comparing numbers by race and ethnicity. This is a general assessment of participation in the following situations as reported in the block grant, and may not match what the programs themselves report.

From 2008 to 2009:
The overall census estimates of children 0-19 in Montana increased.
The estimates of the percent of children in single parent households decreased.
The percent of children in TANF families increased.
The number of children enrolled in Medicaid increased.
The number of children enrolled in SCHIP increased.
The number of children living in foster home care decreased.
The number of children enrolled in the food stamp program increased.
The number of children enrolled in WIC increased.
The rate of juvenile crime arrests decreased.

The percentage of high school drop-outs decreased.

Although the Current Population Survey (CPS) is the only source of data on the percent of children in a household headed by a single parent, the sample size for Montana is so small that it does not always provide valid estimates. During a discussion with the U.S Census Bureau about the CPS estimates for Montana, they recommended not using it as a data source for this measure. However, as it is the only data source available on single parent households, the data are reported for white and American Indian only, as these are two largest population groups (by race) in the state.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	231622	10832	0	2010
Percent in household headed by single parent	0.0	0.0	29.4	2010
Percent in TANF (Grant) families	2.8	3.2	0.0	2010
Number enrolled in Medicaid	63732	3071	0	2010
Number enrolled in SCHIP	24764	729	0	2010
Number living in foster home care	2374	157	115	2010
Number enrolled in food stamp program	53436	51832	1604	2010
Number enrolled in WIC	24971	1830	0	2010
Rate (per 100,000) of juvenile crime arrests	4456.8	3028.1	0.0	2010
Percentage of high school drop-outs (grade 9 through 12)	4.3	4.3	0.0	2010

Notes - 2012
Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html).

Data are from the US Census Bureau via the Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Estimates for single parent households by ethnicity for 2010 do not appear to accurately reflect the population, thus only the total for single parent households is reported.

MT TANF Demographic Data. Data are for Federal Fiscal Year 2010.

The data are children 0 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pull by child's DOB, race and ethncity and are unduplicate count. Data source is MT Medicaid Querypath.

Data are from MT Healthy Montana Kids (CHIP) for 2010.

MT Supplemental Nutrition Assistance Program (SNAP) Data. Data are for 2010.

The source is from the MT State WIC Program. Data are for FFY 2010. Data are final.

Numerator: MT Incident-Based Reporting System. MT Board of Crime Control data from 2010. Denominator data are from 2010 census estimates.

Data Source MT Office of Public Instruction. 200-2010 school year.

Data source is the Child and Family Services Division of MT DPHHS for 2010.

Narrative:
The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates. For additional discussion of this indicator, see Health Status Indicator 09A

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	86773
Living in urban areas	163892
Living in rural areas	85463
Living in frontier areas	0
Total - all children 0 through 19	249355

Notes - 2012
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state.

Narrative:
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition provided by the National Center for Frontier Communities. The total population of youth 0-19 in those 49 frontier counties is 141,666 (55% of all 0-19 year olds in the state). Likewise, there are 114,643 youth age 0-19 (45% of the total) living in non-frontier counties in the state. Metropolitan/ Micropolitan designation used from CEIC. Metro is a subset of Urban, therefore it is also included in the urban population. Urban population= Metro+Micro, Rural is everything else.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	971032.0
Percent Below: 50% of poverty	5.4

100% of poverty	13.5
200% of poverty	35.1

Notes - 2012

Narrative:
Data Source: The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	241409.0
Percent Below: 50% of poverty	9.6
100% of poverty	21.4
200% of poverty	45.0

Notes - 2012

Narrative:
The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator.

F. Other Program Activities

The health of the maternal and child health population, which encompasses women of childbearing age (15-44 years of age), including pregnant women, infants, children, youth, (including those with special health care needs) and their families, is of critical importance to the state and nation. Infants and children deserve excellent health services, and the Family and Community Health Bureau (FCHB) has a major role in ensuring that those services are available and accessible through the Title V MCH Block Grant Program. The FCHB also recognizes that education is intrinsically related to public health, and that a truly healthy population is one that is prepared to assess its own needs and plan accordingly. Education and health services work hand-in-hand to improve the lives of all Montanans.

Montana's 2011 MCH Block Grant application provides a look at how the FCHB, through partnerships with public and private organizations will strive to meet the needs of the MCH population.

The Primary Care Office (PCO) contracted with a private company for conducting a Dental Provider Survey, with the results primarily used for determining health professional shortage areas. Additional PCO work includes Primary Care and Mental Health Provider surveys in FY 2011.

Montana's Native American mortality rate is higher than that of the Caucasian rate and the overall rate. The state will continue addressing the state outcome measure assessing the Native American Infant Mortality Rate.

The Director of the Department of Public Health and Human Services has created the Best Beginning Communication Strategic Planning Committee, of which the Maternal and Child Health Coordination (MCHC) and WIC Section Supervisors are key members. The Committee is charged with promoting best beginning services for parents of infants and children 0 to 5 years of age. The Best Beginning services tie in with the MCH toll-free hotline which is a partnership between the FCHB and Healthy MT Kids (formerly known as CHIP).

The Children's Special Health Services (CSHS) Section continues to address how best to solicit information from the CYSHCN parents. Family representatives on the CSHS committee provide input to the FCHB regarding family concerns and needs.

The Governor's Office provides annual Tribal Relations training on issues that impact the Tribal Nations of Montana and the state-tribal relationship. FCHB supervisors and support staff have attended previous trainings and will continue to attend future trainings.

/2012/
The Primary Care Office (PCO) contracted with a private contractor that conducted Primary Care and Mental Healthcare Provider Surveys, with the results primarily used for determining health professional shortage areas. The data is also accessible for other DPHHS programs for grant applications and determining future activities that may require a healthcare professional.

The MCHC and WIC Section Supervisors contributed to several projects undertaken by the Best Beginnings Communication Strategic Planning Committee, which met throughout 2011. A project that is anticipated to be launched in August, 2011 is the Best Beginnings Calendar, a monthly calendar highlighting training opportunities, resources, and other activities for parents of children 0 to 5.

As noted elsewhere, the CSHS Section will be conducting a comprehensive CYSHCN needs assessment by December 2011. This information will be valuable for continuing to assess their needs for access to services such as healthcare and transitioning to adulthood.
The toll free hotline remains a partnership with the Healthy Montna Kids Program.
//2012//

G. Technical Assistance

The Maternal and Child Health Coordination (MCHC) Section is requesting technical assistance in developing action guides based on best practices for the top five National Performance Measures and for the seven new State Performance Measures. The new State Performance Measures address emerging health issues in Montana and the MCHC section would like to provide MCH contractors with credible action guides to address their performance measure selection and effect positive change in their communities.

The state Fetal, Infant, and Child Mortality Review (FICMR) Coordinator and MCH Epidemiologist request technical assistance on implementing the use of the Child Death Review (CDR) Case Reporting System. Guidance would include assistance with training local FICMR review teams on the use of the CDR.

Montana's Oral Health program requests technical assistance to improve and support the coordination and reporting of dental screenings recommended by Association of State and Territorial Dental Directors. The MCHC would like to provide training and information sessions/workshops for the Oral Health Partners who conduct the dental screenings. The trainings would include information on the recommended procedures for conducting the screenings, reporting the results of the dental screenings and information on dental services

available to low-income and at risk children which can be communicated to parents.

Montana's Oral Health program requests technical assistance to support the Access to Baby Child Dentistry (AbCd) program by providing guidance, leadership, technical assistance, and/or educational materials to AbCd providers/coordinators around the state who are faced with the challenge of assisting children aged 0-3 establish a dental home and low-income mothers/pregnant women receive critical dental care.

The MCHC Section requests technical assistance to develop new communication methods in order to relay and obtain relevant feedback and communication to and from MCH partners. The MCHC Section would like to provide web based, quarterly updates regarding MCH services and also provide assistance and guidance in meeting MCH goals. MCHC would also use the new communication methods to receive quarterly report/application materials from MCH contractors.

Montana's immunization rank according to the National Immunization Survey is 50th in the nation. Montana is focused on improving its rate by providing education to the MCH BG and Vaccine For Children contractors. The FCHB, in partnership with MT's Immunization Program, is focused on improving the immunization rate. Dr. Paul A . Offit, an American pediatrician specializing in infectious diseases and an expert on vaccines, immunology, and virology would be a speaker at an immunization conference.

/2012/

The FCHB's technical assistance requests include:

The local FICMR Teams have expressed an interest in adapting the CDR Case Reporting System whereby if adapted the time previously spent on completing and submitting paper FICMR forms to the state could be spent on prevention activities. If MT were to adapt the CDR Case Reporting System, the local FICMR Teams and the State FICMR Coordinator would need to be trained on the new system.

Attendees at the 2011 Family and Community Health Bureau Conference expressed an interest in having training on home visiting, focusing on the challenges associated with working with families with multiple high risks related needs. MT will be implementing evidence-based home visiting programs with the ACA MIECHV funding opportunity and will continue to support the current Public Health Home Visiting program. Home visiting training would benefit both programs.

//2012//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2010		FY 2011		FY 2012	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	2435138	2430627	2435138		2430627	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	2135677	2901266	2358969		1816886	
4. Local MCH Funds *(Line4, Form 2)*	3590998	3766725	3777376		3871097	
5. Other Funds *(Line5, Form 2)*	0	0	0		0	
6. Program Income *(Line6, Form 2)*	1114333	1474325	1046041		1666306	
7. Subtotal	9276146	10572943	9617524		9784916	
8. Other Federal Funds *(Line10, Form 2)*	20406359	22527163	22531055		20206929	
9. Total *(Line11, Form 2)*	29682505	33100106	32148579		29991845	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2010		FY 2011		FY 2012	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1292312	1788863	1595215		1579159	
b. Infants < 1 year old	1220309	1179536	1255402		1244907	
c. Children 1 to 22 years old	2738309	3239129	2717490		3135787	
d. Children with	1798893	2098563	1820878		2168843	

Special Healthcare Needs						
e. Others	1809727	1866449	1798819		1250392	
f. Administration	416596	400403	429720		405828	
g. SUBTOTAL	9276146	10572943	9617524		9784916	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		93713		97260	
c. CISS	105000		132000		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	130000		130000		130000	
g. WIC	15035980		17012511		14272338	
h. AIDS	1367835		1260714		1260714	
i. CDC	0		0		0	
j. Education	0		0		0	
k. Other						
Affordable Care Act	0		0		663933	
Immunization	715645		0		540294	
Oral Health	0		0		226798	
PHBG FP	140434		126000		126000	
Title X FP	2406547		2474866		2454077	
UNHBS	299000		299000		273447	
WIC Farmers Market	57353		57353		57353	
WIC Peer Counseling	0		203849		104715	
Immunization	0		741049		0	
WIC peer counseling	53921		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2010		**FY 2011**		**FY 2012**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	3988114	4118494	4004151		3548140	
II. Enabling Services	2011403	2604826	2304937		2510896	
III. Population-Based Services	2034981	2395456	1994812		2287463	
IV. Infrastructure Building Services	1241648	1454167	1313624		1438417	
V. Federal-State Title V Block Grant Partnership Total	9276146	10572943	9617524		9784916	

A. Expenditures

The Family and Community Health Bureau (FCHB) Financial Specialist and the Public Health and Safety Division's Fiscal Bureau Analyst maintain the budget documentation for Montana's Maternal Child Health Block Grants, including assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant 2009 Annual Report and 2011 Application reflect the importance of local partners for providing MCH services to the population. For FY 2011, approximately 41% of the MCHBG will be distributed through contracts with 55 of the state's 56 city-county health departments.

Montana, along with most other states, is not initiating new programs at this point, instead carefully monitoring state funding and working to maintain existing services. The FCHB will continue to seek additional financial resources, as well as develop new and maintain existing relationships with public and private partners for the intent of increasing the services to Montana's maternal child health population.

The following is a summary of Forms 3, 4, and 5.

Form 3:

Montana's total expenditures to support MCH services has increased by about $2 million over the last five years. Local and state funds and program income have increased, especially since 2007, while federal support has decreased. Increases are attributable to ongoing commitment of local funds to MCH services, state funding to support new and expanded MCH programs, such as a newborn screening follow up program and contraceptive support, and active pursuit of billing funding to support clinics for children with special health care needs. See attached table and chart for Form 3.

Form 4:

Montana's expenditures by population group differed only slightly from 2008 to 2009. An increase of about $150,000 in administrative costs is attributable to cost allocation increases at the state agency as well as to slight increases in administrative costs at the local level.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

/2012/

Maternal and Child Health Coordination (MCHC) Supervisor is responsible for the MCH Block Grant. The MCHC Supervisor works with the FCHB Financial Specialist and the Public Health and Safety Division's Fiscal Bureau Analyst, who are responsible for maintaining the budget documentation for the MCH Block Grant. They are also responsible for assuring compliance with state and federal regulations and completion of the Financial Status Reports.

Montana's MCH Block Grant 2010 Annual Report and 2012 Application reflect the importance of local partners for providing MCH services to the population. For FY 2012, approximately 41% of the MCHBG will be distributed through contracts with 53 of the state's 56 county health departments.

The ACA MIECHV funding opportunity provided Montana with the capacity to implement, at the local level, evidence based home visiting model (s). At the time of the MCH Block

Grant submission, one county health department, working in collaboration with the tribal health department, will implement Parents As Teacher pending the receipt that the Updated State Plan Notice of Grant Award. It is anticipated that additional home visiting models will be implemented in FY 2012. The state also applied for a ACA MIECHV Development Grant for the purposes of addressing the infrastructure capacity of up to 25 communities identified through the ACA MIECHV Needs Assessment as at risk communities.

The FCHB will continue to seek additional financial resources, as well as develop new and maintain existing relationships with public and private partners for the intent of increasing the services to Montana's maternal child health population. This is due in part to the 2011 Legislative session approved the Public Health and Safety Division 2013 biennial budget request at approximately $3.1 million or 2.4% less when compared to the 2011 biennium. For more information go to: http://leg.mt.gov/css/fiscal/reports/2011-session.asp#ba2013. The budget decrease had minimal impact on the FCHB as it is primarily funded through Federal grant opportunities; however, other agencies that also provide services to the MCH population were less fortunate.
The following is a summary of Forms 3, 4, and 5.

Form 3:
This reflects the decrease in the federal and state general and special revenue funding support. There was an increase for local MCH funding support.

Form 4:
There was a slight increase in the overall Federal-State MCH grant partnership due in part to a decrease in the administrative costs, as noted in the budget report and in the Section titled Other MCH Capacity and the one time only increase for a CSHS special project in FY 2012. The other Federal fund amount reflects the overall decrease in federal funding.

Form 5

Expenditures for direct health care, enabling, population-based, and infrastructure building services continue to vary from year to year, due in great part to the local MCH contractor's yearly expenditure reports.

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B. Budget

Montana's proposed Maternal and Child Health (MCH) Block Grant budget for FFY 2011, as reflected on Form 2, includes the following budget items:

Primary and Preventive Services for Children: This budget item includes the anticipated amount to be spent for infants, children and their families. At the state level, this line item reflects the Maternal Child Health Coordination Section and county level MCH contractors who are responsible for providing these services. The FFY 2011 amount is $809,683.

Children with Special Health Care Needs: This budget items includes the Children with Special Health Services Section's budget of $730,541 plus $108,125 from the county level MCH contractors. The FFY 2011 amount is $838,666.

Title V Administrative Costs: This budget item includes the state indirect total of $174,087, plus an anticipated amount of $57,322 from the county level MCH contractors. They are allowed to use up to 10% of their award for administrative costs per the MCH Administrative Rule 37.57.1001. The FFY 2011 amount is $231,409.

The unobligated FY 2011 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2011 is $2,358,969 which includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program, the newborn screening program, and family planning programs. The local county level MCH contractors are anticipated to overmatch their allocated MCH Block Grant fund amount. The FFY 2011 local county level MCH amount is $3,777,376.

The MCH Program income for FY 2011 is $1,046,041.

Montana's FY 2011 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $9,617,524. Montana also receives additional federal grant funds, i.e. SSDI, CISS, Title X, Immunization, Universal Newborn Hearing Screening, which total $3,902,117.

For FY 2011, Montana's state MCH budget total is: $32,148,579.

/2012/
The proposed 2012 MCH Block Grant budget reflects the anticipated decrease in the state's federal allocation. If it appears that additional funds will be awarded, the expended budget will reflect the increased amount.

Primary and Preventive Services for Children: There is a slight decrease in the anticipated amount for this line item attributable to a decrease in the MCH BG allocation. These funds benefit infants, children and their families as served by the county health department contractors and for MCHC Section staff members.

Children with Special Health Care Needs: As noted on Form 2, this line item is approximately eight percent more than FY 2011. For FY 2012, CSHS will receive a onetime only increase for a Cystic Fibrosis special project.

Title V Administrative Costs: The county health department contractors are allowed to expend up to 10% of their MCH BG amount for administrative costs, which for FY 2012 are projected to be $70,100. The state administrative costs ($155,195) reflect an analysis of decreasing from 13.5 to 10.1 FCHB/FTEs being supported with 2012 MCH BG funding.

The unobligated FY 2012 balance is $0. Montana continues to budget and expend to the level of the annual award.

The State MCH matching fund amount for FY 2012 is less than FY 2011. The $1,816,886 reflects the loss of state funding for the Women and Men's Health Section's family planning programs and state level support for the MCHC Section. The match includes state general funds for the Public Health Home Visiting/ Montana's Initiative for the Abatement of Mortality in Infants Program and the newborn screening program. The local county level MCH contractors are anticipated to overmatch their allocated 2012 MCH Block Grant fund amount with the projected amount at $3,871,097.

The MCH Program income for FY 2012 is $1,666,306 which reflects billing income from a new CSHS clinic and either improved Medicaid billing or Medicaid billing reporting by county health departments.

Montana's FY 2012 Maintenance of Effort remains at $485,480, resulting in the Federal-State Title V Block Grant Partnership as $9,784,916. Montana also receives additional federal grant funds, i.e. ACA MIECHV, SSDI, Title X, Immunization, Universal Newborn

Hearing Screening, which total $20,206,929.

For FY 2012, Montana's state MCH budget total is: $29,991,845.

//2012//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.